Taunton and Somerset NHS
NHS Foundation Trust

Annual Report and Accounts and Quality Account

2017-18

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Contents

Welcome from the Chairman

This has been another year of very substantial achievement for Taunton and Somerset NHS Foundation Trust in the face of increasing financial pressures across the Somerset health economy and the NHS more generally.

I would like to thank all my colleagues for their dedication to caring for our patients, supporting each other and rising to the financial, operational and weather related challenges which the past year has thrown at us. We were one of the first hospitals to be inspected under the new CQC inspection regime and were rated 'Outstanding' for caring and 'Good' overall. More information can be found on page 14.

It has also been an extraordinarily successful year for our hospital in being recognised in prestigious awards for innovative and patient centred care, including the HSJ Awards, HSJ Patient Safety Awards and HSJ Value awards covering fantastic improvements in services from maternity to catering as well as the implementation of various apps including the HANDi paediatric app.

These achievements are a credit to the talent, resourcefulness and sheer hard work of our colleagues. Their commitment, above all to great patient care, shone through in our latest staff survey results which once again put us in the top 20% for colleague engagement, and the Trust is in the top five trusts in the south of England for the number of colleagues who said they would recommend the hospital as a place to work or have treatment. More information about this can be found from page 66.

I would like also to thank our many friends throughout Somerset for their huge support. It is impossible to list everything in this summary but a few highlights include the £650k raised by our terrific League of Friends for our new interventional X-Ray Facility; the £800k raised so far, again with help from League of Friends and the Somerset Unit for Radiotherapy Equipment (SURE), towards our £1m target for a new MRI scanner campaign, for which we are privileged and delighted to have HRH The Countess of Wessex as our Royal Patron; and the fleet of four by four vehicles which emerged from volunteers in the local community which kept our hospital transport working when Taunton was under 'red alert' for snow.

The warmth of local support is truly humbling and an inspiration to all at the Trust to try still harder to maintain the highest standards of patient care. I am sure the combination of dedicated staff and warm support from our local community were key factors in our being awarded £79.5m by the Secretary of State for Health to upgrade our theatres and critical care. This underscores your hospital's position as a key part of the Somerset health economy.

I have suggested previously that the structures of health care in Somerset need to develop to ensure we provide seamless integrated patient centred care. As part of this drive to improve our services and our patients' experience of our care, the Trust Board agreed in May 2017 to work more closely with Somerset Partnership NHS Foundation Trust. Subsequently, in early 2018, both boards agreed to explore a potential merger and development of the strategic case has commenced. In support of this collaborative working, a joint executive team was appointed during the autumn of 2017.

We also appointed Peter Lewis as joint Chief Executive of both organisations having bid a fond farewell to our previous Chief Executive, Sam Barrell, who took up a new opportunity at the Francis Crick Institute in September. I would like to thank Sam for all of her hard work during her time here as Chief Executive and again to congratulate Peter on his appointment and to thank him for his ongoing commitment and progress so far on developing the alliance.

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. I commend our respective boards and councils of governors for their vision in supporting this development at the heart of which lies a determination to provide the best care for patients and prevent organisational barriers getting in the way. Our new arrangements have already shown great benefit not least during the winter period by helping us to make best use of our collective resources.

Strong collaborative working involving our partners at Yeovil District Hospital and Somerset County Council has also brought improvements for patients. For example, Somerset's Home First Service has helped reduce delays in discharge from Somerset's acute hospitals and get patients home sooner, with appropriate support.

After last year's small surplus we ended this year with a deficit of £3.5m (before asset impairments and the net effect of capital donations) which was heavily impacted by the very adverse weather conditions in the last quarter of the year resulting in additional costs and loss of revenue on planned elective surgery. Operationally, the hospital has been very busy and we deeply regret the impact on patients when we have been unable to see them as quickly as we would like or when we have unfortunately been forced to cancel operations, sometimes at short notice, as a result of the hospital being so full. This deficit is part of a much larger total for the Somerset health system as a whole which again reinforces the need for greater integration.

For the coming year we have agreed with our health and care partners in Somerset to focus on the system as a whole rather than on individual organisations. We want more investment to go towards treating patients closer to home, with consequent benefits for patient, and to reduce excess demand for acute care. At the same time increased resource as a national priority is to be allocated to mental health care. Whilst these factors may have an impact on the financial performance of the Trust in isolation, we believe they are in the best interests of patients and the long term financial sustainability of the total Somerset health system.

We are so proud of the highly committed and caring people working across our services, those on the front line and those in support. On behalf of the Board, I would like to thank all my colleagues for their remarkable commitment to our patients, their carers and families. We remain extremely grateful for the continued support we continue to receive from our patients, our carers, our volunteers and governors, and the wonderful contribution made by the charities that support us, including our League of Friends and SURE who continue to generously provide donations that make a real difference to patients.

We look forward to progressing our alliance with Somerset Partnership NHS Foundation Trust in the year ahead and working in an integrated manner with our other partners in the Somerset health and social care system to provide the best possible to all who use our services across Somerset and the wider region.

……

Colin Drummond, OBE, DL, Trust Chairman, 24 May 2018

Performance Report

Overview of performance

The purpose of the overview is to provide a short summary about Taunton and Somerset NHS Foundation Trust ("the Trust" or "Musgrove Park Hospital"), its purpose, strategic objectives (and any key risks to the achievement of those objectives) as well as details of how we have performed over the year.

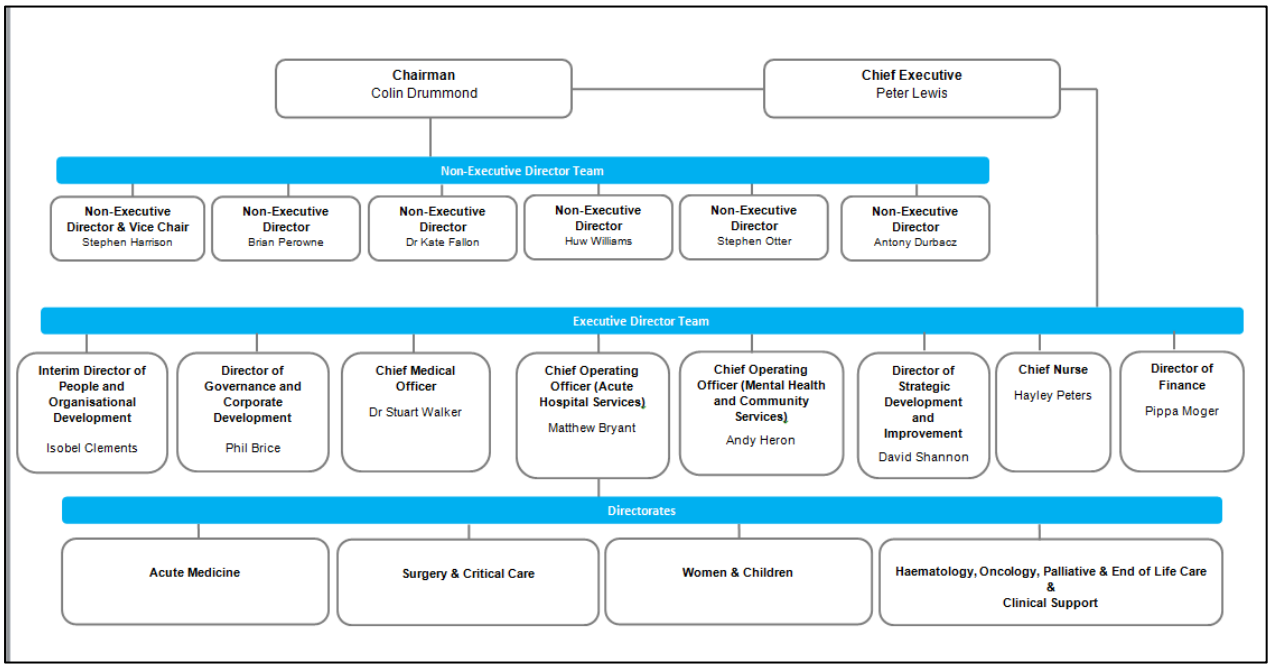
Brief history and structure of Taunton and Somerset NHS Foundation Trust

Taunton and Somerset NHS Foundation Trust was established in 2008 when we were awarded foundation trust status. The Trust is considered as a medium-sized provider of acute hospital services and serves a local population of over 340,000, as well as providing some specialist and tertiary services for Somerset's whole population of around 544,000.

In addition to inpatient, outpatient and emergency care services, the Trust operates a high dependency and intensive care unit, 16 operating theatres, and numerous medical and surgical wards to provide care, meeting the full range of patient need. Musgrove Park Hospital has a fully equipped diagnostic imaging department operating 7 days per week, and a purpose-built cancer treatment centre which includes chemotherapy and radiotherapy facilities for both inpatients and outpatients.

Taunton and Somerset NHS Foundation Trust is registered without conditions as a healthcare provider with the Care Quality Commission (CQC).

Details of the Trust's governance and reporting arrangements are set out within the annual governance statement. In summary:



Purpose, activities/business model and strategic objectives for Taunton and Somerset NHS Foundation Trust

We are a values-driven organisation, conscious that "together, we make the difference." Our values are at the heart of service planning, recruitment and the operational running of services for patients. These are: "one team", "putting our patients first", "leading and listening", and "striving for the best". The Trust's mission is "working together for a healthy Somerset", recognising the role that we play in the health of the whole population, working in partnership with other health and social care services in the county. These values underpin the Trust's strategic objectives and priorities, which for 2017/18 were:

<table>
<tr><th colspan="2">Strategic Objectives</th></tr>
<tr><th>Care</th><th>Performance and Improvement</th></tr>
<tr><td>Deliver improved outcomes and satisfaction for patients through a person-centred approach to service provision.</td><td>Implement the improvement and innovation strategy to improve services and achieve the triple aim of improved health, better care and lower cost</td></tr>
<tr><td>Deliver and maintain the highest standards of clinical care, 7 days per week.</td><td rowspan="2">Ensure that the trust maximises funds for capital investment, including charitable funds, to help deliver capital plans for new developments which actively manage and mitigate risks with buildings and equipment.</td></tr>
<tr><td>Deliver levels of performance that are in line with plans, including waiting times for A&E, RTT, cancer and diagnostics</td></tr>
<tr><td>Transform care processes through digital working to improve safety, outcomes and efficiency.</td><td>Ensure delivery of short term financial plans and financial sustainability for the medium and long term.</td></tr>
<tr><th>Colleagues</th><th>Community</th></tr>
<tr><td>Implement the organisational development plan, creating an environment where colleagues feel confident, supported and empowered to deliver quality services.</td><td>Understand the Trust's contribution to the Somerset sustainability and transformation programme and ensure that contribution is delivered in order to improve the health of the population, quality and sustainability of services.</td></tr>
<tr><td>As the Trust and Somerset Partnership work more closely together, ensure that a shared, collaborative and positive culture is created which leads to unified services and satisfied colleagues.</td><td rowspan="2">Through the alliance with Somerset Partnership, work with primary care, social care, public health and voluntary sector partners to improve the health of the population and integrate services in order to deliver high quality care.</td></tr>
<tr><td>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.</td></tr>
</table>

During 2017/18, the Trust continued to provide the full range of the services expected of a district general hospital, primarily from Musgrove Park Hospital in Taunton. We also provided clinics for various specialties at numerous community hospitals (e.g. endoscopy and orthopaedic services from Bridgwater Community Hospital) and from other community venues across Somerset. The Trust continues to develop links with GPs and other primary care professionals so that care can be delivered in a way which reduces unnecessary hospital admissions.

The Trust's business model remains focused on the delivery of high quality and safe services. The Trust's largest source of income is NHS services paid for by the Somerset CCG, the local commissioners of NHS health services.

The Trust had a turnover of £308.9m in 2017/18 (£299.9m in 2016/17).

The Trust also provides a substantial number of specialist services, often at a sub-regional or regional level. These include radiotherapy and some dental services, as well as some specialist surgical areas. These are paid for by other commissioners including NHS England.

The Trust has a private patient unit which operates all year round and delivers significant additional income, as well as expanding choice for local people.
The environment in which the Trust operates continues to be operationally and financially challenging. Like all hospitals in England, Musgrove Park Hospital has been busier than ever in 2017/18, with record numbers of patients attending A&E, and increasing demand in almost all services.

The Trust continues to explore innovative ways to address these challenges. This year has seen expansion of the JETT therapies team to facilitate faster discharge and more timely therapy input to aid recovery. The "Home First" service has commenced, allowing patients to return to their place of residence more quickly and formulating onward care packages tailored more specifically for their need. And the integrated front door (IFD) service has started, providing dedicated pathways for specific types of presentation at A&E. The IFD service has been shortlisted for a Health Service Journal (HSJ) Value Award due to the positive impact it has had on patients experiencing A&E, and all the service innovations this year have helped to create additional capacity and make sure that patients are treated in the right place at the right time.

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 Somerset Partnership NHS Foundation Trust and explore a potential merger. This alliance is being developed in support of Somerset's Strategic Transformation Plan (STP) and subsequent development by the commissioners of a Health and Social Care Strategy to better integrate services across the county.

Key to this will be the alignment in 2018/19 of already-similar objectives and values, and as an alliance we are taking a dual approach to developing our strategy and service provision. The overarching strategy will follow these principles for the approach to delivery of services across Somerset:

- 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.

<u>Statement from the Chief Executive on the Trust's performance/achievements and key risks / issues</u>

This has been a difficult year for the NHS as a whole and the Trust continues to face profound operational and financial challenges.

Demand for services continues to rise, and is at unprecedented levels. The population served by the Trust is growing and becoming proportionately older. The Somerset population is already older than the average for England, and is becoming more so. The ageing population is one of the reasons why demand for services continues to grow. The rural nature of much of Somerset presents a further challenge. There also remain significant shortages of doctors and nurses in some specialty areas. The Trust maintains a corporate risk register outlining what it perceives as its key challenges. This is supplemented by risk registers within directorates, to identify, manage and mitigate risk. The most significant risks identified in the corporate risk register are as follows:

- Financial challenges and failure to achieve control total.
- Operational pressures having an impact on the quality of care provision and the delivery of the Trust's operational performance standards (RTT, 62 day cancer, diagnostic waiting times and A&E).
- Management of demand across the system, particularly in emergency care.
- Age of the estate.
- Key clinical staffing vacancies, particularly in nursing.
- Recruitment, training and retention of key clinical staff.

The Trust continues to work with partners as part of the STP and the alliance with Somerset Partnership NHS Foundation Trust to develop strategic plans to address these risks and strategic challenges (see below).

Key developments / achievements in 2017/18

- Sustainability and Transformation Plan (STP)

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 Somerset Partnership 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, led by a newly appointed Chief Executive, Peter Lewis. 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 plan 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.

Care Quality Commission (CQC) inspection

Inspectors from the CQC visited the hospital at the end of August 2017 to review four core services – end of life care, urgent and emergency services, surgery and outpatients. In their report, they praised the hospital for the 'outstanding practice' shown in these four areas, resulting in a stronger 'good' rating for the Trust. This is testimony to the efforts of our very hard working, talented staff. The CQC also recognised that since the Trust's last inspection in 2016 we have made a number of improvements across the hospital, which has resulted in higher ratings for our emergency department (A&E), surgery and end of life care. As part of the CQC's new inspection arrangements the CQC inspectors also rated the leadership of the hospital as "good". They observed a strong culture for delivering high-quality care and highlighted our focus on improvement.

Across all domains, the report rated Musgrove as 'outstanding' for caring, and 'good' for its services being effective, responsive and well led, with a 'requires improvement' for safety. However, inspectors said that they are confident that the trust has taken the right action to improve safety of services, which will be inspected at a later date.

- Primary care strategy

A key component of the Trust's corporate strategy is to work more closely with primary care to explore a more integrated approach to providing services, centred on the needs of patients. As closer working relationships have developed, the Trust has established a new more integrated form of relationship with Warwick House Medical Practice in Taunton. From 1 April 2017, the Trust has held the contract to provide primary care services at Warwick House Medical Practice, which involves directly employing and managing all staff at the practice, including the GPs, who will continue to provide primary care services as salaried GPs. This development has presented a really exciting opportunity to ensure patients moving between hospital GP care can do so appropriately and seamlessly.

- Digital and improvement programmes

As part of the global digital exemplar (GDE) programme, we strive to be open about our use of data and to involve patients/public and colleagues in the design and adoption of new technology. Over the past 12 months we have held a number of public events to raise awareness of the programme and to gain the input required; patients/public and colleagues have attended open events in the hospital concourse and the town centre, as well as focused workshops to share ideas and discuss how new technology could make a real difference to the care provided at Musgrove.

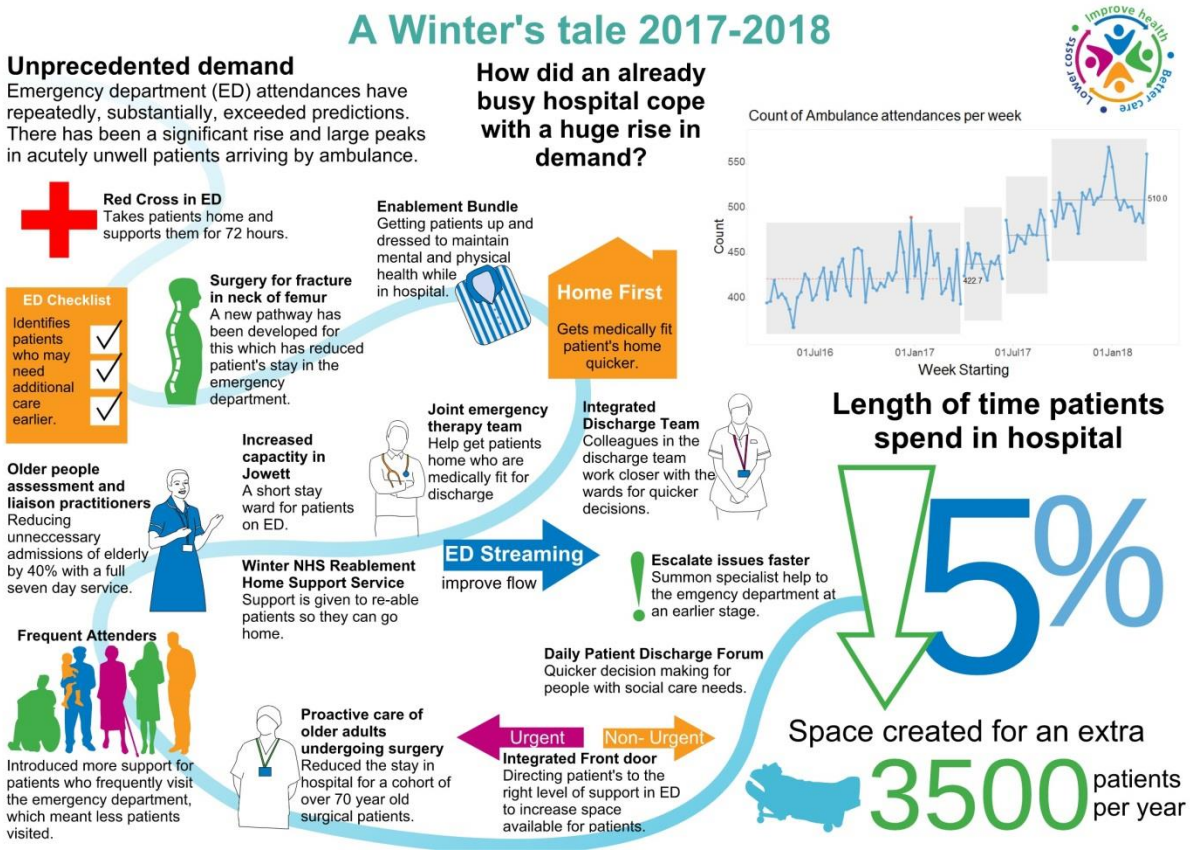
The GDE programme is led by senior clinical colleagues, including two chief clinical information officers (CCIOs), a chief nursing information officer (CNIO) and their deputies, supported by the information management and technology (IM&T) team, in collaboration with the improvement team.

Over the last 12 months we have introduced paper-light working within the outpatient department at Musgrove and some clinics in community hospitals (reducing the administrative burden and ensuring clinicians are always seeing the most up to date information).

Looking ahead, there are some exciting changes planned, with the introduction of mobile working on the wards to support the care and flow of patients, as well as our critical care unit going digital over the summer. We will also be introducing electronic prescribing over the next 12 months, with a real focus on improving patient safety.

Musgrove is also working with partners from health and social care across Somerset to look at how information can be shared to support the direct care of patients/public as part of the Somerset integrated digital eRecord (SIDeR) programme.

In addition to ongoing work with partners to address the Trust's key corporate risks and strategic challenges, we have invested in our improvement team to support colleagues to find innovative solutions to improve the quality of care provision. Some key headlines from the programme are contained in the graphic below:



- New surgical centre

We are absolutely delighted that our hospital has national support to develop a new surgical centre, which will include new theatres and a critical care unit. For our patients and the people of Somerset, it means they will have access to modern, state of the art facilities, that are fit for the future.

The £79.5 million new surgical centre will replace much of Musgrove's ageing 1940s buildings that currently provide care for some of the most critically ill patients in Somerset. It will include:

- Six endoscopy rooms, patient recovery and clinical support areas.
- Eight operating theatres (including two interventional radiology theatres), recovery areas and clinical support.
- 22 critical care beds, all specified for level 2 and 3 critical care patients

The new building will be in a central location on the hospital site, close to other clinical services.

- MRI charitable appeal and Royal Patron

Love Musgrove, the Trust's official charity, was delighted in-year to announce HRH the Countess of Wessex GCVO as the new Royal Patron of its campaign to raise £1m for a new MRI scanner. This essential piece of diagnostic equipment benefits a huge number of patients who may have cancers, cardiac or joint, tendon and muscle problems. Good progress is being made toward achieving the £1m target and the new scanner will help to ensure shorter waiting times for people in Somerset and beyond, as well as providing the hospital with greater overall scanning capacity and allowing us to take part in ground breaking research programmes. We are very grateful to all those who have supported the appeal.

Clinical activity over the four years to 2017/18 was as follows:

NHS Clinical Activity	2014/15	2015/16	2016/17	2017/18
Elective (Spells)	49,366	49,566	49,341	47,505
Non-Elective + Emergency Care (Spells)	40,405	43,291	44,076	47,759
Outpatients (Attendances)	329,413	327,011	367,239*	365,529
A&E (Attendances)	58,593	61,367	64,256	69,772
Deliveries	3,350	3,331	3,284	3,209

*This accounts for pre-operative assessment clinic appointments, which were not previously included.

Operational performance and infection control metrics	Target/ threshold	Performance April 2017-March 2018
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway**	92%	83.6%
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge*	95%	90.8%
Cancer 62 Day Waits for first treatment: • urgent GP referral for suspected cancer • NHS cancer screening service referral	85% 90%	77.4% 95.2%
Clostridium difficile (Trust apportioned cases)	12	18
MRSA (Trust apportioned cases)	0	3

**A&E maximum waiting times - the indicator is expressed as a percentage of all A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge*

*** RTT incomplete pathways – the indicator is expressed as the percentage of patients on an incomplete pathway (i.e. those still awaiting first consultant led treatment) who have waited less than 18 weeks from referral.*

The Trust's performance against the 18 week referral to treatment (RTT) standard has been under the national level all year due to levels of demand being higher than available service capacity. Guided by the Very Intensive Support Team (VIST) the Trust has used the interim management and support (IMAS) capacity and demand modelling tools to understand what level of capacity needs to be provided to meet the levels of demand the Trust is experiencing. This puts the Trust in a stronger position going into 2018/19 to meet demand and in line with the national planning guidance, stop its waiting list increasing in size.

Meeting the A&E 4-hour waiting time standard continued to be challenging during 2017/18. The 95% standard was achieved in April 2017, but like most trusts performance was below the national standard for the year as a whole. Significant growth in demand was seen in both attendances at the Trust's emergency department, but also patients needing to be admitted as an emergency. Part of this growth came from patients needing to attend the emergency department from the Weston Hospital catchment area, following the decision supported by the Trust to close the Weston Area Health Trust emergency department overnight from July 2017. The overall high levels of growth in emergency demand experienced in 2017/18 resulted in higher levels of cancellations of patients needing elective surgery which also impacted on the achievement of the RTT waiting times standard.

The Trust continued to implement a programme of improvement work during 2017/18 to support patient flow through the emergency department. This included the piloting of the Home First model of care which facilitates the discharge of medically fit patients out of the hospital. Patients receive an intensive period of reablement in three settings to promote independence and keep patients (for as long as possible) in their usual place of residence. Through Home First and ongoing system-wide work with partner organisations the Trust has been able to keep the number of delayed transfers of care low this year. The Trust also invested during 2017/18 in a new "integrated front door" which has meant a number of patients with minor illnesses or injury have been able to receive treatment more promptly in a GP-led service, fully supported by the wider range of diagnostic services and facilities available in the emergency department.

Performance against the 31-day decision to treatment cancer standards has been strong throughout the year, for both first and subsequent cancer treatments. But like many trusts, Taunton and Somerset NHS Foundation Trust has struggled to meet the 62-day referral to treatment standard for patients referred by their GP with a suspected cancer. The reasons for the failure to meet the 62-day GP cancer standard have been varied and include the complexity of patients being referred, patient choice to defer diagnostic tests or treatment, patients requiring periods of medical deferral to manage other conditions un-related to their cancer, and longer than planned waiting times for diagnostic tests. A multi-professional cancer summit was held by the Trust in July 2017 to identify further opportunities to reduce 62-day pathway waits from which an improvement plan was developed. This improvement plan will continue to be implemented and added to during 2018/19.

The Trust's performance against the 6-week diagnostic waiting times was below the 99% national standard in 2017/18. Demand for diagnostic tests continues to be high and, like a number of trusts in the South West, the Trust currently has a shortfall in capacity to meet demand. However, plans are in place to install additional CT and MRI scanners during 2018/19, which will help to increase the number of scans we can undertake in the future. Additional gastroenterologists have also been appointed which will help to increase the endoscopy service capacity later in the year.

Unfortunately, the Trust had three cases of MRSA bloodstream infections in 2017/18. Multi-disciplinary reviews were completed to identify the source of the infection and any areas of sub-optimal practice that may have contributed to the case. Opportunities to improve a) MRSA screening and b) checking patient histories for any previous history of MRSA were identified and this learning was shared and improvement actions put in place.

In 2017/18, the Trust had a total of 18 trust-attributed Clostridium difficile cases (defined as specimen with a positive toxin test result taken on or after the fourth day of admission). This was a sharp increase from the previous year when there were only 8 cases identified. However, there has been a general increase across Somerset this year compared to last year, and this may have had an impact on the number of hospital cases. Further information about this is contained within the quality report.

All Trust-apportioned cases are thoroughly investigated to assess whether there was any lapse in care that may have contributed. These assessments are subsequently peer reviewed and validated with the Trust's commissioners. Learning has included ensuring appropriate antimicrobial prescribing and compliance with hand hygiene, and learning was shared with the appropriate clinical staff and improvement actions taken. Further information about this is contained within the quality report.

Going concern

As part of the accounts preparation process, International Accounting Standards (IAS1) require the directors to assess the foundation trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 2.13, the directors are mindful of table 6.2 of the FReM, which emphasises that: "the anticipated continuation of the provision of a service in the future as evidenced by inclusion of financial provision for that service in published documents, is normally evidence of going concern".

The Trust has reported a deficit for 2017/18 and is forecasting a deficit for 2018/19. The forecast deficit is based on a number of assumptions including the delivery of cost improvement programmes. The Trust has assumed it will receive financial support from the Department of Health and Social Care during the course of 2018/19 in order to meet its liabilities and continue to provide healthcare services. The extent and nature of the financial support from the Department of Health and Social Care, including whether such support will be forthcoming or sufficient, is currently uncertain, as are any terms and conditions associated with the funding. The existence of such material uncertainty may cast doubt about the Trust's ability to continue as a going concern. The Trust will apply for cash support in line with current NHS funding policy.

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts. The expectation is informed by the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in the published documents. Contracts for Service, being the NHS Standard Contract 2018/19 has been signed with the Trust's main commissioners.

These are the two lines that we changed yesterday in the account accounts, I assume the other two lines below you don't want

These accounts have been prepared on a going concern basis.

The accounts do not include any adjustments that would result if the Foundation Trust was unable to continue as a going concern.

Performance analysis

The purpose of this section is to provide a detailed performance analysis and explain how the Trust measures performance.

How the foundation trust measures performance

The Trust has a robust process for the measurement of performance, which triangulates quality, workforce and financial indicators. The Trust's approach is known as the performance assurance framework (PAF) process. Each directorate has its own PAF, split into four areas: patients, people, operational delivery and finance / improvement. This is similar to a balanced scorecard approach, in line with the recommendations of Lord Carter's recent review of NHS services.

The PAF is reviewed monthly. The process involves the directorate manager, directorate clinical director, representatives from HR, finance, the operational performance and information teams and others. Each directorate reports on numerous indicators across the four PAF domains. These include all key clinical, operational and financial targets to ensure that the NHS mandate, NHS constitution, local quality and financial targets are met.

Further information about the PAF process and how the Trust measures performance is included from page 80.

Environmental sustainability

The Sustainable Development Unit (SDU) reports to NHS England and Public Health England on the progress all health care providers have made towards sustainability goals. This section of the annual report outlines the action taken during 2017/18 in developing the Trust's Sustainability Strategy (Carbon Reduction Management Plan) which takes its priorities from the Sustainable Development Assessment Tool (SDAT). The SDAT has replaced the Good Corporate Citizen (GCC) and will provide more in depth detail on areas where focus needs to be directed to comply with the carbon emissions reduction required by the Climate Change Act 2008.

Our total energy performance during last year was hampered by the fact our combined heat and power unit is not operating. The Trust continues to consider options for recommissioning the unit with the supplier to have it back in service next year. The Trust has successfully recruited an Energy Manager to support the estates team to further refine engineering controls and develop further innovation. Funding is currently being sort for replacing light fittings to LED.

Solar film has been installed to all wards and corridors on level 1 and 2 in both the Queens and Duchess buildings at the Musgrove Park Hospital site, as well as endoscopy. The solar film deflects heat and UV rays during the summer and in winter helps to keep heat. It also offers more privacy for our patients. This year has seen an increase of 1.25 % in degree day heating due to the colder weather from the last financial year but an overall reduction in energy usage of 6% per patient contact.

Efficiency savings since baseline year 2007 based on usage of services per patient contacts

	2007/8	2013/14	2014/15	2015/16	2016/17	2017/18
Patient contacts	322,320	468,007	481,127	484,566	525,999	533,774
Electricity per KWh	28.97	12.30 (3.88 was produced from renewable sources and CHP)	18.06 (5.42 was produced from renewable sources and CHP)	19.44 (4.31 was produced from renewable sources and CHP)	20.06 (2.17 was produced from renewable sources and CHP)	21.34 (CHP not operational during this period)
Gas per KWh	79.92	41.23	59.67	51.24	44.59	39.33
Water per m3	0.38	0.18	0.23	0.24	0.23	0.23
Clinical waste generated per patient contact kg	1.29	2.03	2.11	1.98	0.71	0.72

The table below provides actual consumption data with regard to energy and waste. The columns on the right show the % change from base year and previous year

	2007/08 Base Year	2016/17	2017/18		% Difference 2016/17 to 2017/18	Cumulative % difference from 2007/08 baseline figure to date
Gas – kWh	25,759,758	23,455,988	20,997,751		-10%	-18%
Imported electricity –kWh	9,339,410	11,677,973	11,394,383		-2%	22%
Water m^3	124,006	119,159	122,146		2%	-1.5%
Clinical waste – tonnes	416	375	383		2%	-8%

The table below provides last years' data on reported carbon emissions. The reduction in CRC is due to the input of green renewable technologies into the national grid which has been reflected in the conversion factor applied per kWh of both electricity and gas. Carbon emission costs have now risen to £18.30 per tonne.

	2010/11 Base Year	2014/15	2015/16	2016/17	2017/18	% change from 2015/16to 2016/17	% change from base year
CRC - carbon reduction commitment	11,092	10,566	9,955	9,895	7,873	-20%	-29%
FITs (£) - feed in tariffs	N/A (introduced this year)	21,151	19,723	17,092	23,871	+40%	+13%

Comparison with other similar acute hospitals suggests that the Trust performs well for energy and water consumption and carbon emissions. For energy consumption and carbon emissions the Trust is in the lower quartile, and only just above for water resources. The key objectives for the Trust are ambitious to further reduce our footprint to meet the mandatory targets of the Climate Change Act 2008.

A Sustainable Development Management Plan (SDMP) is in the process of preparation which will set key objectives for the next 3 years to enable the Trust to progress towards meeting the mandatory targets of the Climate Change Act 2008. The plan reflects ambitious targets to reduce energy consumption, water consumption and waste produced by 10% over the next 3 years. In order to achieve these targets SALIX funding will both standardise and modernise the electrical lighting and plant machinery on a "Save to spend basis". For reduction in waste Government initiatives including the deposit scheme for beverage glass, plastic and metal containers, the inventory management roll out and better segregation will be essential in reaching our target.

Emergency preparedness, resilience and response (EPRR)

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. These could be anything from severe weather to an infectious disease outbreak or major transport incident. Under the Civil Contingencies Act (2004), and the Health and Social Care Act as amended (2012), NHS organisations and providers of NHS funded care must demonstrate they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. Taunton and Somerset NHS Trust is audited against the EPRR core standards annually. The 2017 audit reported that the Trust is considered to be substantially compliant with the EPRR core standards and has formally reported the same to NHS England and the Somerset CCG.

Throughout 2017, the risk of emergencies has been assessed and emergency and business continuity plans have been improved to ensure that patient safety is maintained. The Trust has been represented at multi-agency meetings and exercises to facilitate information sharing. A number of mass casualty exercises have been undertaken internally and externally to strengthen the multi-agency response to a mass casualty incident.

The Trust has a rolling programme of live, table-top and communications exercises that are designed to test and develop our plans. The Trust is required to hold a live test every three years, a table-top test every year, and a communications cascade every six months. Whenever possible, the Trust strives to ensure that our testing is held in a multi-agency context. This is to provide familiarisation with other organisations and to assist with benchmarking our response with our partners. Exercises provide invaluable insight into the operational implementation of our plans and highlighted the areas of the plans that require further development.

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. The Trust is a member of the Avon and Somerset Local Health Resilience Partnership, the purpose of which is to ensure that effective and coordinated arrangements are in place for multi-agency emergency preparedness and response in accordance with national policy and direction from NHS England. The Trust also has an internal Emergency Preparedness Resilience and Response Group to oversee its plans, key risks and mitigations and to develop staff training.

Social, community and equality, diversity, anti-bribery and human rights

We believe in equality and value diversity, both as a provider of health services and as an employer. The Trust is committed to eliminating discrimination and protecting the nine protected equality characteristics.

To improve the patient experience we have a highly skilled, motivated and diverse workforce. This means that we are fair and unbiased, and accept differences between individuals and value the benefits of diversity. This is demonstrated by the everyday practices, policies and procedures to which we adhere. We aim to be pro-active in meeting the changing needs of our diverse communities, and to provide fair access for all in an environment where dignity and individuality are respected.

As a provider of health services and as an employer, the Trust is committed to:

- Eliminating unlawful discrimination, harassment and victimisation across all the protected characteristics.

- Advancing equality of opportunity between different groups.

- Fostering good relations between different groups.

Building on the work undertaken in the previous years to ensure momentum in this area, the Trust has made progress against many equality and diversity issues this year. The equality and diversity steering group has representation from across many clinical and corporate areas. Its purpose is to review, rate evidenced activity and set priorities against the equality delivery system. The priorities cover areas such as "better health outcomes", "improved patient access and experience", "a representative and supported workforce" and "inclusive leadership".

The Trust has good evidence that its services are commissioned, procured, and delivered to meet the health needs of its local communities. Service provision is responsive both to community need and patient feedback. Where services are procured by the Trust, suppliers are selected as per clear rules, and are required to adhere to strict standards including those related to equality and diversity. People's health needs are assessed and met in appropriate and effective ways. Care and risk documentation includes individual patient plans. There are specific plans available for patients with dementia and learning disabilities, and for vulnerable adults. There is a multi-faith patient chaplaincy service, and the Trust's *care after death policy* includes meeting the needs of diverse patients. Transitions from one service to the other, for people on care pathways, are made smoothly, with everyone properly informed. When people use the Trust's services, their safety is prioritised and efforts are made to ensure that they are free from mistakes, mistreatment and abuse. The sign up to safety work programme in particular helps to ensure this.

At Taunton and Somerset NHS Foundation Trust we value our reputation for top quality care and financial probity, and we conduct our business in an ethical manner. The Board carries out its business in an open and transparent way and members of the public are able to attend portions of our Board meetings. The Trust is committed to the prevention of bribery, fraud and corruption. We expect all organisations / contractors instructed by our organisation to demonstrate a comparable commitment in order to do business with us. This enables us to reassure our patients, members and stakeholders that public funds are protected and safeguarded.

The Bribery Act 2010 makes it easier to tackle the issue of bribery which is a damaging practice. Bribery can be defined as 'giving someone a financial gain or other advantage to encourage them to perform their duties improperly or reward them for having done so'. To limit our exposure to bribery we have an *anti-fraud, bribery and corruption policy* and a *whistleblowing policy* and we are currently implementing a new *managing conflicts of interest policy*. These policies apply to all staff and individuals who act on behalf of our organisation.

Taunton and Somerset NHS Foundation Trust employs a counter fraud manager who investigates, as appropriate, any allegations of fraud, bribery or corruption. The success of our anti-bribery approach depends on our colleagues playing their part and we therefore encourage colleagues, service users, patients, visitors and others associated with the Trust to report any suspicions to the counter fraud manager or to the NHS Counter Fraud Authority.

Details of overseas operations

The Trust has no direct overseas operations. However, for any operations carried out on behalf of overseas visitors, the costs are recovered via a reciprocal agreement with the Somerset CCG.

The Trust has no overseas operations and has no branches outside of the UK.

Key post-year developments
None identified.

Statement of comprehensive income (SoCI)

The financial year ending 31 March 2018 has been challenging for the Trust due to a range of financial and operational pressures, particularly over the winter period. As a result of these pressures, the Trust ended the year with an overall deficit of (£3.5m) (on the financial reporting basis employed by NHS Improvement) before asset impairments of (£2.0m) and the net effect of capital donations of £0.4m, reflecting a statutory deficit of (£5.0m).

Income

The Trust's total income from activities has increased from £299.9m in the previous financial year to £308.9m in 2017/18, an increase of £9.0m (3.0%). The principal reason is that income from patient care activities has increased by £8.9m (3.4%). Within this, £12.0m was from increased levels of non-elective activity offset by a £3.2m reduction in elective activity. In addition, the Trust received £6.7m of sustainability and transformation funding (STF) income from the Department of Health and Social Care(£8.8m in previous year). The greatest proportion of the Trust's income is derived from the provision of health care for patients in Somerset.

Income generation from private patient activity remained at £2.4m.

Expenditure and cost improvement plans
Total operating expenditure increased in 2017/18 by £9.8m (3.3%) to £308.2m. In order to offset the impact of inflation and other cost pressures, the Trust set a savings target of c4.3% of operational expenditure. The Trust set itself a stretch target of £13.4m savings and achieved a total of £13.2m.

Total pay costs were £186.2m in the year, an increase against the 2016/17 spend figure of £177.6m (4.8%). The expenditure increases were mainly the result of the 1% pay increase awarded nationally to NHS staff along with additional staffing costs associated with workforce transformation and skill mix changes, dealing with increased demand particularly for non-elective activity and the TUPE transfer of staff from Warwick House (a GP practice now run by the Trust).

Operating non-pay expenditure increased by £1.2m (1.0%) on the previous year figure of £120.8m.

Expenditure on rechargeable high cost drugs prescribed to patients went up in 2017/18 and increased drug usage accounts for £1.9m of the overall increase in total operating expenditure. These costs are associated, in particular, with increased use of a number of approved high cost drugs in an increasing range of conditions, which are reclaimable through the specialised services commissioners and the cancer drugs fund.

There have been one-off impairment costs of £2.0m (£5.0m in 2016/17) incurred within the financial year relating to the revaluation of building, equipment and land.

Statement of financial position (SOFP)

Non-current assets (land, buildings and equipment) comprise the most significant elements, by value, of the SOFP and amount in total to £182.8m as at 31 March 2018 (£172.0m as at 31 March 2017). Included within the net book value movements for the year were impairments of £2.0m and revaluations of £9.4m. These changes were made following the annual independent revaluations of land and buildings.

The Trust's borrowing at 31 March 2018 amounted to £28.8m (down from £30.6m at 31 March 2017). In previous years the Trust has been able to fund capital expenditure through loans and the remaining are the balances of a loan taken to fund a portion of the cost of the Jubilee Building, the Trust's PFI initiative for the Beacon Centre and a finance lease for an energy project. A radiology managed facility service was entered into by the Trust which has added £0.4m to borrowing.

Other significant investments in the hospital's infrastructure reflected in the SOFP include:

- Improvements to the Trust's estate and infrastructure (£2.4m).
- Primary care streaming in the emergency department (£1.0m)
- Continuing development of the new electronic patient records (EPR) system and global digital exemplar programme (£3.3m).
- IT upgrades (£0.9m).
- Major medical equipment replacement (£1.8m).
- Radiology equipment and installation works (£1.6m)

Total capital investments in 2017/18 amounted to £13.3m (£8.3m in 2016/17). Capital investment in 2018/19 is expected to be £16.6m including the planned development work on the theatres and critical care redevelopment.

Other features of the SOFP

The level of cash deposits decreased from £8.0m at 31 March 2017 to £4.9m at 31 March 2018.

Other accounting matters

Note 33 of the accounts outlines any *related party* transactions. This shows that none of the Board members, or key management staff, or parties related to them, has undertaken any material transactions with the Trust.

In line with the requirements for foundation trusts to prepare accounts in compliance with International Reporting Standards, the Trust has reviewed all of its accounting policies for the year ended 31 March 2018. No material changes have been made to those used in 2016/17.

The Trust Board acts as the corporate Trustee for the Taunton and Somerset NHS Foundation Trust General Charitable Funds, registered with the Charities Commission. This charity also administers charitable funds on behalf of Somerset Partnership NHS Foundation Trust. The charity continues to receive donations from benefactors and uses these funds for the benefit of both patients and staff. The charitable fund annual report and accounts for 2017/18 are published separately and are available from the Trust on request.

Future plans

The financial position of the Trust continues to be challenging. The Trust plan for the 2018/19 financial year has a forecast deficit of £11.2m after taking into account savings plans of 3.4% of turnover. Interim revenue support will be required to support operational delivery. The Trust continues to work closely with system partners to address the significant financial challenges in Somerset.

……
Peter Lewis, Chief Executive, 24 May 2018

Accountability report

NHS foundation trust code of governance disclosures

Taunton and Somerset 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.

How the Board of Directors and Council of Governors operate

The Board and Council of Governors exercise their functions as set out in the Trust's constitutional documents, relevant legislation and the regulatory framework.

The general duty of the Board, and of each director, is to act with a view to promoting the success of the Trust so as to maximise the benefits for its members. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. Guidance is available in the Trust's *standing financial instructions* to determine the Board or Committee from which approval of decisions is required.

The Council of Governors is made up of elected and nominated governors who provide an important link between the hospital, local people and key organisations, sharing information and views that can be used to develop and improve services. It is chaired by the Trust Chairman. The Lead Governor is Mike Bickersteth.

The Council consists of 29 governors:

- 15 publicly elected governors from four constituencies (Taunton, West Somerset, East Somerset and Rest of England).

- Five staff governors elected by self-nomination and constituency voting, representing a minimum of three out of the following five staff groups:

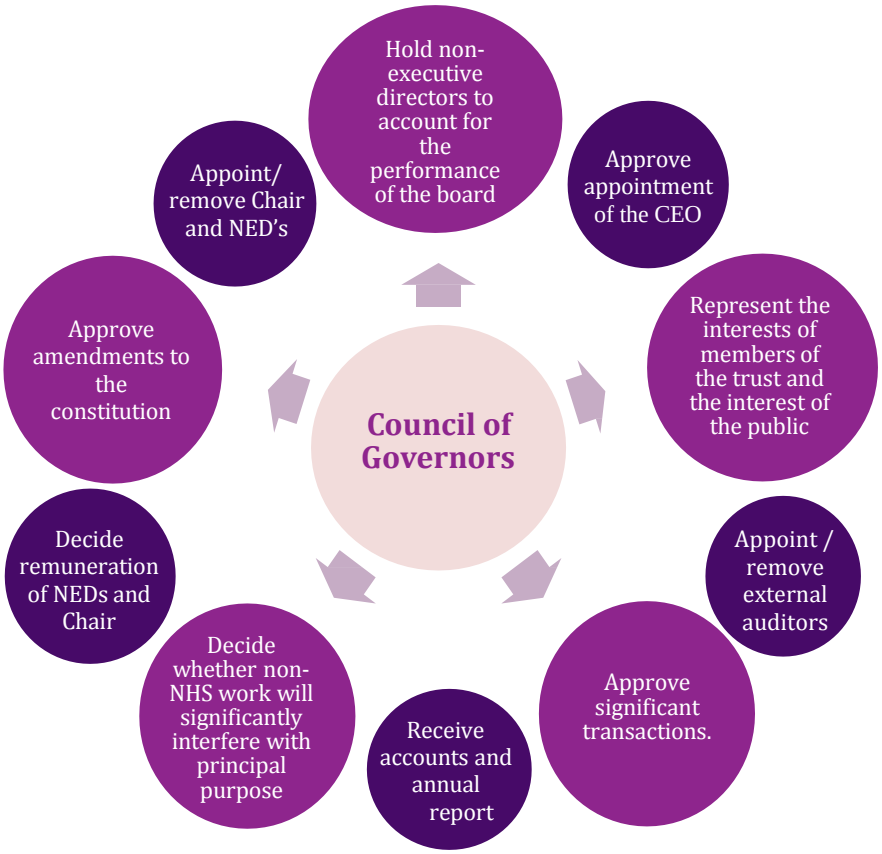
  - Medical and dental
  - Nursing and midwifery
  - Hotel and estates services
  - Clerical, administrative and managerial
  - Allied professionals, scientific and technical.

Eight partnership/local authority governors appointed by partnership or stakeholder organisations.

A youth governor representative.

The Council of Governors is responsible for appointing or removing the Chairman of the Trust and other non-executive directors. This requires the approval of three-quarters of the members of the Council of Governors.

The Council of Governors is also responsible for the following:



During 2017/18, the Council of Governors carried out the following statutory duties:

- Approved the re-appointment of the Chairman (Colin Drummond).
- Approved the appointment of the Chief Executive Officer (Peter Lewis) for Taunton and Somerset NHS Foundation Trust and then as Chief Executive Officer for the alliance with Somerset Partnership NHS Foundation Trust.
- Approved the re-appointment of the Vice-Chair (Stephen Harrison).
- Approved the re-appointment of the Senior Independent Director (Kate Fallon).
- Approved the appointment of the Lead Governor (Mike Bickersteth).
- Received the Trust's annual accounts, annual report, quality report and auditor's report.
- Influenced the development of the Trust's quality report, including selecting the quality report priorities.

- Influenced the development of forward business plans through the Strategy Working Group.

- Represented the interests of members and the public by obtaining and reviewing their feedback via the good to know log at the Patient Care Working Group and planning engagement activities (such as setting up governor surgeries in 2018/19) at the Communications and Engagement Working Group.

The Council of Governors has three sub-committees which meet outside the formal meetings of the full Council. The committees are chaired by public governors and focus on specific issues in relation to strategy, patient care and membership and communications. The committees provide reports and recommendations, as appropriate, for consideration by the Council of Governors. The Trust's non-executive and executive directors regularly attend the Council of Governors and the sub-committee meetings on a regular basis, to develop an understanding of the views of governors and members.

Governors are also encouraged to attend and observe meetings of the Board as part of their role. In addition, the Council of Governors has an Appointments Committee which is responsible for considering the remuneration, terms of employment and performance of the non-executive directors of the Trust Board (including the Chairman). The Appointments Committee is chaired by the Trust Chairman, except when it relates to him, when it is chaired by the Senior Independent Director.

In the event of dispute between the Council of Governors and the Board of Directors, in the first instance the Chairman, on the advice of the Secretary, and such other advice as the Chairman may see fit to obtain, shall seek to resolve the dispute. If the Chairman is unable to resolve the dispute, he shall appoint a special committee comprising equal numbers of directors and governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute. If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chairman may refer the dispute back to the Board of Directors who shall make the final decision.

A full list of governors who were in post on 31 March 2018 and details of changes during the year is set out below together with details of the number of Council of Governor meetings attended by each governor during 2017/18.

<u>Elected governors – public constituency</u>

Name	Constituency	Date elected/ re-elected	Term of office	Attendance at Council meetings
Mike Bickersteth	West Somerset	Dec 2015	3 years	4/4
Kate Butler	West Somerset	Dec 2016	3 years	3/4
Judy Cottrell	Taunton Deane	Dec 2016	3 years	3/4
Melanie Devine	Taunton Deane	Dec 2017	3 year	2/2

Mike Free	West Somerset	Dec 2015	3 years	2/4
Judith Goodchild	West Somerset	Dec 2016	3 years	3/4
Diana Griffith	East Somerset	Dec 2016	3 years	3/4
Phil Hodgson	Rest of England	Dec 2015	3 years	2/4
Jeanette Keech	Taunton Deane	Dec 2016	3 years	4/4
Vivienne Knighton	Taunton Deane	Dec 2016	3 years	1/4
Alan Peak	West Somerset	Dec 2016	3 years	3/4
Patrick Simpson	West Somerset	Dec 2016	3 years	2/4
John Slater	East Somerset	Dec 2016	3 years	3/4
Vacancy	East Somerset	-	-	-
Vacancy	Taunton Deane	-	-	-

Public governor changes during 2017/18

Name	Constituency	Date elected/ re-elected	Term of office	Reason	Attendance at Council meetings
Anne Elder	Taunton Deane	Dec 2016	3 years	Resigned	2/2
Ronald Wood	East Somerset	Dec 2012	3 years	Resigned	0/2
Dudley Price	Taunton Deane	Dec 2016	3 years	Moved out of constituency	3/4

There were two governor elections this year in two of the public constituencies: Taunton Deane and East Somerset. The election resulted in the following changes in the constituencies:

Taunton Deane: Melanie Devine was elected
East Somerset: There were no nominations for this constituency, therefore the post has remained vacant this year. We will seek nominations during the next election round taking place in 2018.

Elected governors – staff constituency

Name	Constituency	Date elected/ re-elected	Term of office	Attendance at Council meetings
Manuel Blanco-Guzman	Medical and Dental	Dec 2017	3 years	2/2
Graham Cartwright	Allied Professional	Dec 2015	3 years	4/4
Angus Maccormick	Allied Professional	Dec 2015	3 years	2/4
Lynn Pearson	Clerical and Admin	Dec 2017	3 years	4/4
Julie Vale	Nursing and Midwifery	Dec 2017	3 years	1/2

Staff governor changes during 2017/18

Name	Constituency	Date elected/ re-elected	Term of office	Reason	Attendance at Council meetings
Andy Dodd	Estates	Dec 2014	3 years	Not re-elected	1/2
Dr Timothy Zilkha	Medical and Dental	Dec 2014	3 years	Did not re-stand	1/2

There were two governor elections this year in the staff constituency. The election resulted in the following changes in the constituency:

Julie Vale and Manuel Blanco-Guzman replaced Andy Dodd and Dr Timothy Zilkha following the governor election process.

Partnership governors

Name	Stakeholder organisation	Appointed/ re-appointed	Attendance at Council meetings
Gill Slocombe	Sedgemoor and West Somerset District Councils	Dec 2016	1/4
Will Chandler	GP Governor Representative	Sept 2013	0/4
James Hunt	Taunton Deane Borough Council	Aug 2011	3/4
Jos Latour	Universities of Plymouth and Bournemouth	Aug 2017	2/4
Sue Steele	South Somerset District Council	Dec 2014	3/4
Rod Williams	Somerset County Council	June 2017	1/4
Vacancy	Somerset Partnership NHS Foundation Trust	-	-
Vacancy	Somerset Clinical Commissioning Group	-	-
Vacancy	Youth Governor	-	-

Partnership governor changes during 2017/18

The following partnership governors relinquished their roles during 2017/18:

Name	Stakeholder organisation	Appointed/ re-appointed	Term of office	Attendance at Council meetings
Patricia Livesey	Universities of Plymouth and Bournemouth	Sept 2015	3 years	0/0

Christopher Le Hardy	Somerset County Council	July 2014	3 years	0/0
Sue Balcombe	Somerset Partnership NHS Foundation Trust	November 2015	3 years	0/1

Register of interests

A register of interests for governors is maintained. A copy is available on the Trust's website at www.tsft.nhs.uk (as part of the Council of Governors' meeting papers) or by emailing governors@tst.nhs.uk

It is not considered that there are any significant interests held by governors which may conflict with their responsibilities, but it should be noted that Judith Goodchild is also Chair of Healthwatch and as such does not comment on the Trust's quality report in this capacity.

Engagement with members

We recognise the importance of having a strong and engaged membership. With circa 16,900 members (public and staff combined), the Trust has access to the local population, interaction with which helps to improve hospital services. The focus of the Trust's membership strategy, which is set and monitored by the Board, is on improving meaningful engagement with its members. In support of this aim, the Trust engages with its members via email, through the publication of Musgrove Matters (which is a popular communication tool) and through events and meetings such as the annual members' meeting held in September each year. The Trust's membership (which is reviewed by the Communication and Engagement Working Group on behalf of the Council of Governors and the Board), is broadly representative of the population it serves. According to 2011 census data, the majority of Somerset residents are 'white British'. Somerset also has an increasingly older population, and the Trust's membership reflects this trend.

Contact information for members

Members may contact governors via a dedicated e-mail address at governors@tst.nhs.uk or through the website at www.tsft.nhs.uk

Membership as at 31 March 2018
Public membership

Constituency	Number of Members 31.3.18	Number of Members 31.3.17	increase/ decrease over year	% population who are members*
Taunton	5,351	5,294	+57	4.7%
West Somerset	3,021	2,921	+100	1.9%
East Somerset	1,871	1,827	+44	0.2%
Rest of England	1,956	1,769	+187	N/A

*Based on 2001 Census data

Staff membership*

Constituency	Number of Members 31.3.18	Number of Members 31.3.17	increase/ decrease over year
Total staff	4,240	5,128*	(888)*

*In 2017/18, the Trust undertook a quality assurance assessment of the membership database (for staff) to ensure that the data aligns with that Trust's internal electronic staff record. As part of this process we no longer include bank staff in the staff category and the lower figure for staff in 2018 reflects this adjustment. In 2018/19 further data cleansing will be undertaken to ensure the Trust's database is compliant with the requirements of GDPR coming into force in May 2018.

Directors' report

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

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Statement of disclosure to the auditors

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

Income disclosures

The Trust has met the requirement set out in Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that income for the provision of goods and services for the purposes of the health service in England has been greater than its income from the provision of goods and services for any other purposes.

The Trust has made no political or charitable donations.

Better payment practice code

The Trust is obliged to comply with the public sector's better payment practice code (BPPC), which targets the payment of all undisputed invoices by the later of the due date or 30 days following the receipt of goods or valid invoice.

Details of the Trust's compliance with this code are:

	2017/18		2016/17	
	No	£m	No	£m
NHS Invoices				
Total invoices paid	1,484	10.657	1,766	12.529
Total invoices paid within target	653	4.938	990	7.103
Percentage of invoices paid within target	44.0%	46.3%	56.1%	56.7%

	2017/18		2016/17	
	No	£m	No	£m
Non - NHS Invoices				
Total invoices paid	88,817	164.731	80,519	113.645
Total invoices paid within target	42,077	109.558	52,007	80.367
Percentage of invoices paid within target	47.4%	66.5%	64.6%	70.7%

	2017/18		2016/17	
	No	£m	No	£m
Total Invoices				
Total invoices paid	90,301	175.388	82,285	126.174
Total invoices paid within target	42,730	114.496	52,997	87.469
Percentage of invoices paid within target	47.3%	65.3%	64.4%	69.3%

The Trust did not incur any interest liability for late payment of invoices.

Internal audit function, appointment/reappointment and removal of external auditor and audit committee role

The Audit Committee is a committee of the Board. As part of its role, the Audit Committee seeks assurance on the adequacy of internal control processes within the Trust. To achieve the required levels of assurance, the Committee utilises the various audit functions of management, internal auditors (BDO) and external auditors (PwC) and counter fraud. This meets mandatory NHS audit standards. The Audit Committee also takes assurance from the views of other external agencies about the Trust's procedures and from the Governance and Quality Committee and Finance Committee. The Audit Committee has the right to enquire into any area of the Trust's workings without hindrance.

The Audit Committee agrees the internal audit work plan each year and receives the reports and follow-ups on the issues raised. The internal audit plan is based on the Trust's assurance framework and corporate risk register and is reviewed by the Trust's committee of the Board. Where audits of major issues or risks are identified, managers who are responsible for the areas reviewed are asked to attend the Audit Committee meeting and report on the steps taken to rectify the situation. As for 2016/17, the internal auditors, BDO, have provided a moderate assurance opinion for 2017/18 that the Trust has a sound system of internal control.

The Audit Committee reviews and monitors the external auditor's independence, objectivity and effectiveness at least once per year. The Audit Committee also reviews any non-audit work carried out by the external auditor to ensure that the objectivity and independence of the external auditor is not impaired. The Audit Committee discusses the audit of the Trust's annual report and accounts with the external auditor prior to the Board's approval, in particular any areas of concern arising from work during the year.

The Trust's external audit services are currently supplied by PwC and the current contract was initially awarded for a 3 year period commencing on 1 April 2014 and expires on 30 September 2018 having been extended. Given the alliance with Somerset Partnership NHS Foundation Trust it seemed sensible to align the external audit contract provider across the two trusts and a procurement exercise has been undertaken with the aim to award separate contracts but to the same provider for the two trusts with a commencement date of 1 July 2018.

The cost of other non-audit work undertaken during 2017/18 was £2k. Other non-audit assurance services amounted to £0k.

The Audit Committee approved the external audit plan 2017-18 which outlined how PwC planned to discharge its audit duties for the financial year. The Audit Committee considered the risks which were thought to be either significant in relation to PwC's audit for the year ended 31 March 2018:

- Risk of management override of controls.
- Risk of fraud in revenue and expenditure recognition.
- Valuation of the Trust's land and buildings.
- Going concern.

Throughout the year, the Audit Committee has received and reviewed progress reports from PwC in delivering its responsibilities as the Trust's external auditor, together with other matters of interest such as key technical areas and sector updates. The Audit Committee has confirmed throughout the year that the risks identified in the external audit plan have remained valid.

The Audit Committee receives and monitors the policies and procedures associated with counter fraud. The Trust's counter fraud manager produces a regular counter fraud progress report, giving updates on both reactive and pro-active work and assists the Trust in ensuring it has policies that are compliant with the NHS Counter Fraud Authority and all standards for NHS providers.

<u>NHS Improvement's well-led framework</u>

The Trust has a *governance policy* that describes the arrangements in place for quality governance, including committee structures, accountabilities and reporting requirements. These governance arrangements are discussed in detail in the annual governance statement and quality report.

No material inconsistencies have been identified between the annual governance statement and the report from the Trust's Care Quality Commission (CQC) inspection in 2017. Following receipt of the report in November 2017, an action plan has been developed to address the issues raised. This is monitored by the Trust's executive CQC steering group which reports to the Governance and Quality Committee. Overall the Trust was rated as "good" in its inspection.

The quality report in appendix 1 details the range of work in which the Trust is involved aimed at improving patient care and stakeholder engagement.

Details about the Trust's implementation of NHS Improvement's *well-led framework* can be found in the annual governance statement.

There is a system for internal control that includes the assurance framework and the Trust has an ongoing process for providing assurance on, and improving, the governance of quality, overseen by the Trust's Governance and Quality Committee.

Register of interests

A register of Board members' interests is maintained. A copy is available on the Trust's website at www.tsft.nhs.uk (as part of the Trust Board meeting papers). It is not considered that there are any significant interests held by the directors which may conflict with their responsibilities.

Membership of the Board as at 31 March 2018

A full list of directors who were in post on 31 March 2018 and details of changes during the year is set out below together with details of the number of meetings of the Board, Audit Committee and Board Nomination and Remuneration Committee attended in-year.

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 an entirely joint executive leadership team was appointed to the boards of both trusts during the autumn of 2017. Secondment arrangements have been set up for their roles to the non-employing trust. The details included in the table below relating to Board members that served during the year (including the joint executive team members) are not subject to audit.

*Indicates member of the Audit Committee
+Indicates member of the Board Nomination and Remuneration Committee

Non-Executive Directors

Colin Drummond OBE, DL+	**Chairman (Chair of the Nomination Committee)**	**Appointed:** 1 August 2014 **Re-Appointed:** 1 August 2017 **Term Expires:** 31 July 2020

Colin was appointed Chairman on 1 August 2014. He is also Pro-Chancellor and Chair of Governors of the University of Plymouth. He was Master of the Worshipful Company of Water Conservators for 2007/08 and Chair of the 'WET 10' City Livery Companies from 2008 to 2013. From 1997 to 2015 he was a Trustee, and is now Honorary Vice President of the Calvert Trust Exmoor. He is Trustee of the Water Conservation Trust and President of Wadham College Oxford 1610 Society.

From 1992 to 2013 Colin was Chief Executive of Viridor, a leading recycling, renewable energy and waste management company, and an executive director of Pennon Group PLC. He was then Chairman of Viridor until the end of 2014. Prior to joining Pennon, Colin was Chief Executive of Coats Viyella Yarns Division, an executive director of Renold PLC, a consultant with the Boston Consulting Group and an official with the Bank of England. Colin was Chairman of the Government's 'Living with Environmental Change Business Advisory Board from 2009 to 2015 and of the Environmental Sustainability Knowledge Transfer Network from 2007 to 2013.

Colin holds an MA from Oxford University and an MBA from Harvard Business School where he held a Harkness Fellowship. He was appointed an OBE in the Queen's Birthday Honours 2012 for services to technology and innovation, and a Deputy Lieutenant (DL) of Somerset in 2016.

Board Attendance: 10/10
Board Nomination/Remuneration Committee Attendance: 8/8

Stephen Harrison+*	**Non-Executive Director (Vice-Chair)**	**Appointed:** 1 April 2013 **Re-Appointed:** 1 April 2017 **Term Expires:** 31 March 2020
	Stephen joined the Trust in February 2013 as a designate non-executive director until his formal appointment on 1 April 2013. He worked at Clarks Shoes for his main career. On leaving Clarks, Stephen developed a portfolio of organisational development consultancy work and community activity, including being elected as leader of Mendip District Council. In the NHS he has undertaken non-executive director roles with Bath and West Community Trust, Mendip Primary Care Trust (where he was Chairman), North Somerset Primary Care Trust and finally as Chairman of a cluster of PCTs responsible for health services across Bristol, North Somerset and South Gloucestershire. Stephen is Chairman of YMCA Mendip and is a Trustee of the Lawrence Centre in Wells. He is a governor of Wookey Primary School. **Board Attendance: 10/10** **Board Nomination/Remuneration Committee Attendance: 7/8** **Audit Committee Attendance: 4/4**	
Antony Durbacz+*	**Non-Executive Director (Chair of the Audit Committee)**	**Appointed:** 1 November 2016 **Term Expires:** 31 October 2019
	Antony was appointed as a non-executive director in November 2016. He is a chartered accountant with 25 years' commercial experience as a finance director with major international companies. Antony has held executive leadership roles in blue chip companies in both the UK and Europe. He brings experience of all aspects of business management including financial control, business development, strategic planning and corporate governance. Antony is a Director of Great Western Assurance Growth Ltd, a Director of Knightstone Charitable Housing Ltd, a Director and Shareholder of Liverty Ltd, a Governor at Crispin School and his daughter is a foundation doctor at North Bristol NHS Trust. Prior to 2 March 2018, he was also a Non-Executive Director of Knightstone Housing Group. **Board Attendance: 10/10** **Board Nomination/Remuneration Committee Attendance: 7/8** **Audit Committee Attendance: 4/4**	

Dr Kate Fallon+	**Non-Executive Director** **(Senior Independent Director)** **(Chair of the Finance Committee)** **(Chair of the Remuneration Committee)**	**Appointed:** 1 July 2015 **Term Expires:** 30 June 2018
	Kate was appointed as a non-executive director on 1 July 2015 and came to the Trust with significant experience in the strategic direction and transformation of services within the NHS. She established a completely new NHS trust in 2010, which trebled in size and became the first community trust to be licensed by Monitor as a Foundation Trust in November 2014. Previously Kate transformed her own general practice, taking it from a traditional reactive business to a forward-planning, innovative "beacon site", with a sustained Investors in People accolade. Kate is currently a Trustee of Skills for Health and Chair for the Skills for Justice Enterprise. Her daughter is a Consultant at Taunton and Somerset NHS Foundation Trust. In 2015 she was included in the HSJ "Top 50 NHS Chief Executives" list for her approach to service transformation and the integration of NHS services. **Board Attendance: 10/10** **Board Nomination/Remuneration Committee Attendance: 8/8**	
Stephen Otter+*	**Non-Executive Director** **(Chair of the Governance and Quality Committee)**	**Appointed:** 1 July 2015 **Term Expires:** 30 June 2018
	Stephen was appointed as a non-executive director on 1 July 2015. Stephen started his police career in 1982 in the Thames Valley Police before moving to the Royal Hong Kong Police as an inspector. He then spent 13 years in the Metropolitan Police Service where his career ranged across a number of strategic roles at New Scotland Yard, leaving the force at the rank of Commander. He went on to serve as Assistant and then Deputy Chief Constable in Avon and Somerset Police. Following this, he was the Chief Constable of Devon and Cornwall Police from 2007 to 2012, where he combined leading the 6,000-strong police force with being the national lead on equality, diversity and human rights for the Association of Chief Police Officers. In 2008, Stephen was awarded the Queen's Police Medal. In 2012 he became one of Her Majesty's Inspectors of Constabulary and had the role of inspecting and reporting on policing for the purpose of promoting improvement. He is Chairman of Pluss, Director of Robus Solutions Ltd and an Associate of Cityforum Ltd. **Board Attendance: 10/10** **Board Nomination/Remuneration Committee Attendance: 5/8** **Audit Committee Attendance: 0/1**	

Brian Perowne CB DL+	**Non-Executive Director (Chair of the Charitable Funds Committee)**	**Appointed:** 1 March 2013 **Re-Appointed:** 1 March 2017 **Term Expires:** 29 February 2020
	Brian joined the Trust in March 2013. He brings with him a wealth of experience following a successful career in the Royal Navy which included three major commands and an appointment as Head of Naval Communications. He served as the Chief Executive of the Naval Base at Faslane on the Clyde before being promoted to Rear Admiral in 1996. He was Chief Executive of the Naval Bases and Supply Agency and served as Chief of Fleet Support on the Admiralty and Navy Boards. From 2001–2011 Brian was Chief Executive of The Home Farm Trust, a national charity providing support to adults with learning disabilities. He is Trustee and Vice-Chair of Somerset Sight, Deputy Lieutenant of Somerset, and a Council member - Association of NHS Charities. **Board Attendance: 10/10** **Board Nomination/Remuneration Committee Attendance: 7/8**	
Huw Williams+*	**Non-Executive Director**	**Appointed:** 1 January 2016 **Term Expires:** 31 December 2018
	Huw was appointed as non-executive director designate on 1 July 2015. His position was made definitive as of 1 January 2016. In terms of his background, following graduation he joined Goldman Sachs International in London, progressing from Analyst to executive director in the investment banking division, before moving to Goldman Sachs' private equity arm from 2004-07. During his banking career, he advised on a large number of public and private take-overs and mergers, stock market flotations and public and private debt financings. From 2007-09 he worked for a US private equity fund (Cerberus Capital Partners) as a partner in its European business. Since then, he has focused on being an angel investor, investing in a wide range of private start-up companies, mostly in the UK. He is a non-executive director, LumeJet Print Technologies Limited. **Board Attendance: 10/10** **Board Nomination/Remuneration Committee Attendance: 5/8** **Audit Committee Attendance: 3/3**	

Joint Executive Directors

Peter Lewis	**Chief Executive (Voting)**	**Appointed:** 1 April 2005
	Peter joined the Trust on 1 April 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. Peter was Acting Director of Finance from 21 January 2016 until 28 August 2016. He was Deputy Chief Executive from 2008 until 1 September 2017. He was appointed as the Chief Executive of the Trust from 2 September 2017 and was appointed as joint Chief Executive of the Trust and Somerset Partnership NHS Foundation trust on 4 November 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. During the year, his wife also worked for the Trust. **Board Attendance: 10/10**	

David Shannon	**Director of Strategic Development and Improvement (Non-Voting)**	**Appointed:** 29 August 2016
	David joined the Trust as Finance Director 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. He is a member of the Southwest Pathology Services (SPS) Board. He was appointed as Director of Strategic Development and Improvement of the Trust and Somerset Partnership NHS Foundation Trust on 24 October 2017 following a period of transition with the incoming Director of Finance, Pippa Moger. **Board Attendance: 10/10**	

Dr Stuart Walker	Chief Medical Officer (Voting)	Appointed (Substantively): 23 May 2016
	Stuart was appointed substantively as Medical Director on 23 May 2016 – 30 September 2017. He was appointed as joint Chief Medical Officer of the Trust and Somerset Partnership NHS Foundation Trust on 1 October 2017. He is a Consultant Cardiologist and during his time at Musgrove Park Hospital has also held a number of roles within 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 chief medical officer he champions patient safety and quality improvement. His wife works for the Trust. **Board Attendance: 10/10**	

Hayley Peters	Chief Nurse (Voting)	Appointed (Substantively): 2 December 2015
	Hayley was appointed substantively as Director of Patient Care on 2 December 2015. She was appointed as joint Interim Chief Nurse of the Trust and Somerset Partnership NHS Foundation Trust on 2 October 2017 and was appointed substantively into that role on 6 March 2018. 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's early 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 first Physician's Assistants to practice 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 to improve patient safety, quality and patient experience. **Board Attendance: 9/10**	

Matthew Bryant	**Chief Operating Officer (Acute) (Voting)**	**Appointed:** 11 July 2016
	Matthew joined the Trust in 2014 as Director of Operations and was appointed as Chief Operating Officer in 2015. He was appointed as Chief Operating Officer (Acute Hospital Services) of the Trust and Somerset Partnership NHS Foundation Trust on 1 October 2017. 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. He helped 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 Attendance: 10/10**	
Phil Brice	**Director of Governance and Corporate Development (Non-Voting)**	**Appointed:** 1 October 2017
	Phil joined Somerset Partnership NHS Foundation Trust in 2012, having worked in the NHS since 2000. He worked for the 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 is a member of the NHS Top Leaders' programme. He was appointed as joint Director of Governance and Corporate Development of the Trust and Somerset Partnership NHS Foundation Trust on 1 October 2017. His wife works for Somerset Partnership NHS Foundation Trust, His sister works for Taunton and Somerset NHS Foundation Trust and he is a Director of the Shepton Mallet Health Partnership. **Board Attendance: 5/5**	

Pippa Moger	**Director of Finance (Voting)**	**Appointed:** 2 October 2017
	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 was appointed as Director of Finance and Business Development of Somerset Partnership in June 2013 and was appointed as joint Director of Finance of the Trust and Somerset Partnership NHS Foundation Trust on 2 October 2017. Her stepdaughter works for Yeovil District Hospital NHS Foundation Trust, her son works for Somerset Partnership NHS Foundation Trust and she is a Director of the Shepton Mallet Health Partnership. **Board Attendance: 4/5**	
Isobel Clements	**Interim Director of Director People and Organisational Development (Non-Voting)**	**Appointed:** 1 November 2017
	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 (operating at a deputy level). 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. She was appointed as joint Interim Director of People and Organisational Development of the Trust and Somerset Partnership NHS Foundation Trust on 1 November 2017. Isobel is a member of the Chartered Institute of Personnel and Development. **Board Attendance: 4/4**	

Andy Heron	**Chief Operating Officer (Mental Health and Community Services) and Deputy Chief Executive (Voting)**	**Appointed:** 1 October 2017
	Andy joined Somerset Partnership NHS Foundation Trust in January 2014. He originally qualified as an Occupational Therapist (DIP.COT) and has worked clinically in Cornwall and North Somerset and went on to manage mental health services prior to managing mental health services in Bristol from 1999 – 2006 where he took a central role in integrating NHS and social care services and a 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 Somerset Partnership in 2014 he was 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. His wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services) and he is a Director of the Shepton Mallet Health Partnership He was appointed as Chief Operating Officer (Mental Health and Community Services) for the Trust and Somerset Partnership NHS Foundation Trust on 1 October 2017 and as joint Deputy Chief Executive for both trusts on 4 November 2017. **Board Attendance: 5/5**	

Board members that served in 2017/18 (but are no longer on the Board)

Dr Samantha Barrell CBE	**Chief Executive**	**Appointed:** 23 February 2015 **Stepped Down:**1 September 2017
	Sam joined Taunton and Somerset NHS Foundation Trust as Chief Executive in February 2015 having previously been Chief Clinical Officer at South Devon and Torbay Clinical Commissioning Group (CCG). Sam is a clinician by background, who after training worked as an anaesthetist in large acute trusts in the South East. Alongside her role at the CCG, Sam continued to be a senior GP partner at the Compass House Medical Centre in South Devon. Before that she was Clinical Director of Commissioning and Transition for Torbay Care Trust where her focus centred on improving health and care services for patients through whole system integration. She was awarded a CBE in 2014 for her services to clinical commissioning and integrated care. While working for the Trust, Sam was a member of National Advisory Council of the King's Fund, a member of the Health Advisory Panel of the Institute of Public Policy and Research, a member of the Health Advisory Panel of Whizz Kidz and a member of the South Pathology Services. Her husband was part-owner of four dental businesses based in Devon (part NHS contracts). She stood down from her position as she was appointed as Chief Operating Officer of the Francis Crick Institute. **Board Attendance: 4/4**	
Nick Macklin	**Director of Workforce and Organisational Development**	**Appointed:** 4 July 2017 **Stepped Down:** 31 October 2017
	Nick Macklin joined Somerset Partnership NHS Foundation Trust in October 2015 with 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 more recently, 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. He was appointed as joint Director of Workforce and Organisational Development for the Trust and Somerset Partnership NHS Foundation Trust on 4 July 2017, and stood down from this position on 31 October 2017. **Board Attendance: 1/2**	

Performance evaluation of the Board effectiveness/governance arrangements

All directors, including the Chief Executive and Chairman, have annual performance reviews in line with the Trust's policy for all staff. In addition, the Trust carries out regular reviews of the effectiveness of the Board and all its sub-committees, using the findings to inform Board development. Details about the Trust's implementation of NHS Improvement's *well-led framework* can be found in the annual governance statement, the findings from which also inform the improvement of the Trust's governance systems.

Peter Lewis, Chief Executive, 24 May 2018

Remuneration Report

Non-audited information

The Nomination and Remuneration Committee of the Board comprises the non-executive directors and determines the level of remuneration, terms of service for the Chief Executive and other executive directors. It supports the work of the Chairman in assessing the size, structure and skill requirements of the Board. The remuneration element of the Committee is chaired by the Senior Independent Director, Kate Fallon, and the nomination element of the Committee is chaired by the Trust's Chairman, Colin Drummond.

At present, the Trust employs colleagues under a number of pay and conditions of service (medical and dental contracts, agenda for change and spot salaries). Taunton and Somerset NHS Foundation Trust is amongst one of the very few trusts to have taken advantage of freedoms to implement local terms and conditions for some senior leaders (all executive directors and circa 24 other senior managers) who would ordinarily be subject to nationally agreed agenda for change or very senior manager (VSM) terms. For this group, performance is directly linked to annual pay progression. This includes both objectives and also leadership behaviours. The process of calibration has been introduced to enable reviewers to compare performance in a more objective way. Uplifts are determined by taking a % of the current salary value across this group. Annual pay uplifts are then determined on performance, typically this is in the order of 0% for individuals rated as a 1, 1% for individuals rated as a 2, 1.7% for individuals rated as a 3 and 2% for individuals rated as a 4.

In determining pay, the Nomination and Remuneration Committee seeks to strike a balance between setting pay at a level sufficient to recruit, retain and reward individuals of a high calibre and ensuring best value in the use of public finances. Although staff are not formally consulted on pay rates, increases are set in line with those staff on agenda for change national terms and conditions. For senior staff on spot salaries, performance related pay rises have been made available to ensure that the spot salaries keep pace with pay rises elsewhere in the workforce.

The Trust's *very senior managers' pay policy* (for those on spot salaries) provides arrangements that are designed to:

- Recruit, retain and motivate high calibre staff recognising that roles and individuals covered by this policy will be crucial to the success of the Trust.
- Provide a framework that allows local flexibility and responsiveness to competitive conditions for roles but that is fair and equitable.

- Be consistent with the principles of other pay reforms, such as agenda for change and the consultant contract.

- Reward performance in an objective and consistent way.

- Ensure salary levels represent value for money and within the context of the market situation.

- Take account of the salary benchmark in equivalent roles nationally, within the region and within neighbouring trusts, in the public sector (and private sector where appropriate).

In some cases, an additional responsibility payment may be paid where individual senior managers are required to take on significant responsibilities outside of their core role for an extended period. The allowance should be linked to the proportion of time spent on the additional responsibilities and would not normally exceed 10% of basic salary. Executive members of the Board are employed on contracts with no fixed or specified term, save for the Chief Medical Officer, who is subject to a three year fixed term in respect of his executive role. Notice periods for executive members of the Board are set at six months. No provision is made for additional termination payments. One director was paid £52,000 in lieu of notice during the year. The costs were shared equally between Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust.

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

See page 52 onwards for salary and pension entitlements for senior managers.
See page 37 onwards for details of the membership and attendance of the Nomination and Remuneration Committee.

The Trust is required to disclose the steps it has taken to satisfy itself that the remuneration is reasonable in cases where senior managers are paid more than £150,000 p.a. There are two senior managers currently employed by the Trust who were paid more than £150,000p.a. (the Chief Executive and the Chief Medical Officer). The salaries for these posts have been benchmarked and are commensurate with national, regional and local comparator roles within the NHS, reflecting the very high levels of responsibility associated with the posts, particularly as these individuals have also been appointed to these roles within Somerset Partnership NHS Foundation Trust.

Fair Pay – audited information

The mid-point banded remuneration of the highest-paid director in Taunton and Somerset NHS Foundation Trust in the financial year 2017/18 was £195,000 to £200,000 (2016/17: £190,000 to £195,000).

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. This was 7.8 times (2017/18: 7.8) the median remuneration of the workforce, which was £25,197 (2016/17: £25,074).

In 2017/18, one employee received remuneration in excess of the highest-paid director (2016/17: 1). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind of which there were none in 2017/18. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Where there is a sharing arrangement, it is the cost to the entity of an individual that identifies them as "highest paid" and not the total of that individual's remuneration. Termination benefits are excluded from the calculation of the highest-paid director's salary to avoid disturbing the ratio.

During 2017/18 the Trust appointed a joint executive team with Somerset Partnership NHS Foundation Trust. This increased the composition and the responsibilities of the executive team, who now operate across both trusts as part of an alliance to deliver more joined-up health services for the population of Somerset. This is reflected in their remuneration (see page 52 onwards).

There was no pay freeze for staff in 2017/18.

Expenses of the governors and directors – non-audited information

Expenses of the governors

There were a total of 32 governors in office during the reporting period and there were 14 governors who claimed expenses in that time (reflecting the elections in year). See page 30 onwards for more information. The aggregate sum of expenses paid to governors in the 2017/18 reporting period is £2,627 (2016/17 reporting period is £5,375).

Expenses of the directors

There were a total of 18 directors (11 executive and 7 non-executive) directors in office during the reporting period (16 directors in total as at 31 March 2018). The number of directors who claimed expenses in the reporting period was 11. The aggregate sum of expenses paid to directors (executive and non-executive) in the 2017/18 reporting period was £12,663 (2016/17 reporting period - £12,232).

Salaries and allowances of senior managers 2017/18 – audited information

Name and title		2017/18					
		Salary & Fees	All Taxable Benefits	Pension-related Benefits	Recharge of Remuneration (excluding Pension Recharges) to/from Somerset Partnership	Pension Recharges to/from Somerset Partnership	Total
		(Bands of £5,000) £000	Rounded to the nearest £100	(Bands of £2,500) £000	(Bands of £5,000) £000	(Bands of £2,500) £000	(Bands of £5,000) £000
		a	b	c	d	e	f
Joint Executive Directors with Somerset Partnership NHS Foundation Trust (costs incurred by Taunton and Somerset NHS Foundation Trust (TST))							
Dr S R Barrell	Chief Executive (Note 1)	60 - 65	0	0 - 2.5	n/a	n/a	65 - 70
Mr P S Lewis	Chief Executive (Note 2)	160 - 165	0	120 - 122.5	(60 - 65)	(17.5 - 20)	200 - 205
Mr D A Shannon	Director of Strategic Development and Improvement (Note 3)	120 - 125	0	85 - 87.5	(35 - 40)	(7.5 - 10)	160 - 165
Dr S K Walker	Chief Medical Care Officer (Note 4*)	195 - 200	0	125 - 127.5	(45 - 50)	(7.5 - 10)	265 - 270
Mrs H J Peters	Chief Nurse (Note 5)	125 - 130	0	117.5 - 120	(30 - 35)	(7.5 - 10)	205 - 210
Mr M A Bryant	Chief Operating Officer (Acute Hospital Services) (Note 6)	115 - 120	0	57.5 - 60	(30 - 35)	(7.5 - 10)	135 - 140
Mr A Heron *	Deputy Chief Executive and Chief Operating Officer (Mental Health and Community Services) (Note 7)	n/a	n/a	n/a	25 - 30	5 - 7.5	35 - 40

Mrs P Moger *	Director of Finance (Note 8)	n/a	n/a	n/a	30 - 35	5 - 7.5	40 - 45
Mr P Brice *	Director of Governance & Corporate Development (Note 9)	n/a	n/a	n/a	25 - 30	2.5 - 5	30 - 35
Mr N Macklin *	Director of People and Organisational Development (Note 10)	n/a	n/a	n/a	35 - 40	0 - 2.5	40 - 45
Mrs I Clements	Interim Director of People and Organisational Development (Note 11)	40 - 45	0	17.5 - 20	(25 - 30)	(2.5 - 5)	25 - 30
Salary costs paid by Somerset Partnership NHS Foundation Trust							
Mr A Heron *	Deputy Chief Executive and Chief Operating Officer (Mental Health and Community Services) (Note 7)	115 - 120	400	n/a	n/a	n/a	115 - 120
Mrs P Moger *	Director of Finance (Note 8)	115 - 120	0	n/a	n/a	n/a	115 - 120
Mr P Brice *	Director of Governance and Corporate Development (Note 9)	95 - 100	100	n/a	n/a	n/a	95 - 100
Mr N Macklin *	Director of People and Organisational Development (Note 10)	95 - 100	0	n/a	n/a	n/a	95 - 100
Non-Executive Directors for TST only							
Mr C Drummond	Chair	45 - 50	1,400	n/a	n/a	n/a	45 - 50
Mr S D Harrison	Vice Chair	15 - 20	3,000	n/a	n/a	n/a	20 - 25
Mr B B Perowne	Non-Executive Director	10 - 15	2,200	n/a	n/a	n/a	15 - 20
Dr K J Fallon	Non-Executive Director	10 - 15	0	n/a	n/a	n/a	10 - 15
Mr H R Williams	Non-Executive Director	10 - 15	0	n/a	n/a	n/a	10 - 15
Mr S Otter	Non-Executive Director	10 - 15	0	n/a	n/a	n/a	10 - 15
Mr A Durbacz	Non-Executive Director	10 - 15	2,000	n/a	n/a	n/a	15 - 20

* Employed by Somerset Partnership NHS Foundation Trust with secondment to Taunton and Somerset.

The Trust entered into an Alliance with Somerset Partnership NHS Foundation Trust during 2017/18. As a result, a single executive/management team was formed. The Taunton and Somerset NHS Foundation Trust Board continues to function as a legal entity. The table of salary and pension entitlements of senior managers for 2017/18 includes the full entitlements paid to senior managers during the year (columns a to c). Recharges between the two organisations are shown in columns d and e. The net charge to Taunton and Somerset NHS Foundation Trust is recorded in column f.

Notes

1. Left the Trust on 1/9/2017.
2. Was the Deputy CEO for Taunton and Somerset until 1/9/2017, became the Trust's CEO from 2/9/2017. Was the Joint Deputy Chief Executive from 4/7/2017 until 3/11/2017. Became Joint Chief Executive on 4/11/2017.
3. Was Director of Finance until 23/10/2017 (joint working arrangement with Pippa Moger from 2/10/2017 until 23/10/2017). Became Joint Director of Strategic Development and Improvement from 24/10/17.
4*. Was Medical Director until 30/9/2017, became Joint Chief Medical Care Officer from 1/10/2017 (includes £18K for clinical duties).
5. Was Director of Patient Care until 1/10/2017. Became Joint Interim Chief Nurse from 2/10/2017 and was appointed substantively into that role on 6 March 2018.
6. Was Chief Operating Officer until 30/9/2017. Became Chief Operating Officer (Acute Services) from 1/10/2017.
7. Became Chief Operating Officer (Mental Health and Community Services) from 1/10/2017. Became Deputy Chief Executive as well from 4/11/2017.
8. Became Director of Finance from 2/10/2017, joint working arrangement with David Shannon until 23/10/2017, when became sole Director of Finance.
9. Became Director of Governance and Corporate Development from 1/10/2017
10. Was Director of People and Organisational Development from 4/7/2017 until 31/10/2017.
11. Became Interim Director of People and Organisational Development from 1/11/2017.

Salaries and allowances of senior managers 2016/17 – audited information

Name and title		2016-17						
		Salary & fees	All taxable benefits	Annual performance related bonuses	Long-term annual performance related bonuses	Pension-related benefits	Other remuneration	Total
		(Bands of £5,000) £000	Rounded to the nearest £100	(Bands of £5,000) £000	(Bands of £5,000) £000	(Bands of £2,500) £000	(Bands of £5,000) £000	(Bands of £5,000) £000
		a	b	c	d	e		
Executive directors								
Dr S Barrell	Chief Executive	145-150				27.5-30		175-180
Mr P Lewis	Deputy Chief Executive	145-150				157.5-160		305-310
Mr D Shannon	Director of Finance (from 29.08.16)	70-75				60-62.5		130-135
Dr S Walker	Medical Director (from 23.05.16) *1	165-170				115-117.5		280-285
Mrs H Peters	Director of Patient Care	110-115				155-157.5		265-270
Mr M Bryant	Chief Operating Officer (from 11.07.16)	75-80				70-72.5		145-150
Mr D Allwright	Director of Corporate Planning (to 30.06.16) *2	180-185				15-17.5		195-200
Dr C Close	Medical Director (to 22.05.16)	30-35						30-35
Mr D Hobdey	Director of Finance (to 21.01.16) *4	50-55						50-55

Non-executive directors								
Mr C Drummond	Chair	45-50	1,400					45-50
Mr S Harrison	Non-Executive Director & Vice Chair	15-20	2,100					15-20
Mrs G McComas	Non-Executive Director Vice Chair (to 31.12.16)	10-15	4,000					15-20
Mr G Gracie	Non-Executive Director (to 31.08.16)	5-10	1,100					5-10
Mr B Perowne	Non-Executive Director	10-15	2,000					10-15
Dr K Fallon	Non-Executive Director	10-15	0					10-15
Mr H Williams	Non-Executive Director	10-15	0					10-15
Mr S Otter	Non-Executive Director	10-15	0					10-15
Mr A Durbacz	Non-Executive Director (from 01.11.16)	5-10	600					5-10
Senior manager								
Mr S Sullivan	Turnaround Advisor (to 30.04.16) *3	30-35						30-35

Notes:

*1 Includes £24k for clinical duties.
*2 Includes payment in lieu of notice £70k and £80k agreed redundancy scheme (MARS) payment
*3 Appointed in consultation with NHS Improvement (employed through Hunter Healthcare Resourcing Ltd)
*4 Payment in lieu of notice made in the 2016-17 year from employment during the 2015-16 financial year.

Pension entitlements of senior managers 2017/18 – audited information

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employers Contribution to Stakeholder Pension	All pension related benefits
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	To nearest £100 £	(bands of £2,500) £000
Executive directors									
Dr S R Barrell	0 - 2.5	(2.5) - 0	20 - 25	40 - 45	324	9	346	0	0 - 2.5
Mr P S Lewis	5 - 7.5	10 - 12.5	55 - 60	150 - 155	773	146	919	0	120 - 122.5
Mr D A Shannon	2.5 - 5	7.5 - 10	30 - 35	75 - 80	337	82	419	0	85 - 87.5
Dr S K Walker	5 - 7.5	12.5 - 15	55 - 60	150 - 155	890	129	1,018	0	125 - 127.5
Mrs H J Peters	5 - 7.5	10 - 12.5	35 - 40	90 - 95	445	115	560	0	117.5 - 120
Mr M A Bryant	2.5 - 5	2.5 - 5	30 - 35	80 - 85	417	52	468	0	57.5 - 60
Mrs I Clements (from 1 November 2017)	0 - 2.5	0 - 2.5	10 - 15	30 - 35	179	19	224	0	17.5 - 20
Mr A Heron*	0 - 2.5	(57.5 - 60)	25 - 30	0	444	(37)	412	0	(25 -27.5)
Mr P Brice*	0 - 2.5	2.5 - 5	20 - 25	55 - 60	342	60	405	0	40 - 42.5
Mr N Macklin*	0 - 2.5	0	10 - 15	0	146	20	167	0	12.5 - 15
Mrs P Moger*	2.5 - 5	5 - 7.5	25 - 30	65 - 70	343	55	401	0	75 - 77.5

* Post are shared between Somerset Partnership and Taunton and Somerset Foundation Trust. The full pension figures attributed to the employee have been disclosed in the table above rather than the amount chargeable to the Trusts.

Pension entitlements of senior managers 2016/17 – audited information

	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash equivalent transfer value at 1 April 2016	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2017	Employers contribution to stakeholder pension	All pension related benefits
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	To nearest £100 £	(bands of £2,500) £000
Executive directors									
Dr S Barrell	2.5-5	0	20-25	40-45	280	23	324	0	27.5-30
Mr P Lewis	7.5-10	7.5-10	50-55	140-145	654	97	773	0	157.5-160
Mr D Shannon (from 29.08.16)	2.5-5	5-7.5	25-30	65-70	281	46	337	0	60-62.5
Dr S Walker (from 23.05.16)	5-7.5	10-12.5	50-55	140-145	763	108	890	0	115-117.5
Mrs H Peters	7.5-10	15-17.5	30-35	80-85	332	98	445	0	155-157.5
Mr M Bryant (from 11.07.16)	2.5-5	5-7.5	25-30	75-80	343	63	417	0	70-72.5
Mr D Allwright (left 30.06.16)	0-2.5	0-5	45-50	135-140	826	66	907	0	15-17.5

Notes:

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

The CETV is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of 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.

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 the disclosure applies. The CETV figures, and from 2004-05 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.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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Peter Lewis, Chief Executive, 24 May 2018

Staff report

We are really proud of our colleagues and their achievements. We value our people and their commitment to our patients and our organisation - together, we are dedicated to working as one team to make a difference to people's lives. In this section of the annual report, we describe the ways in which we engage and communicate with our colleagues as well as setting out the number of people we employ and sickness absence data.

Analysis of average number of employees (WTE basis)* – audited information

	Total 2017/18	Permanent 2017/18	Other 2017/18	Total 2016/17	Permanent 2016/17	Other 2016/17
Medical and dental	511	497	14	502	489	13
Ambulance staff	0	0	0	0	0	0
Administration and estates	894	868	27	853	788	65
Healthcare assistants and other support staff	1,109	953	156	1,027	920	107
Nursing, midwifery and health visiting staff	1,136	1,042	95	1,155	1,079	76
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	648	634	13	630	625	5
Healthcare science staff	0	0	0	2	0	2
Social care staff	0	0	0	0	0	0
Agency and contract staff	0	0	0	0	0	0
Bank staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
Total average numbers	**4,298**	**3,993**	**305**	**4,169**	**3,901**	**268**
Of which (numbers of employees (WTE) engaged on capital projects	65	63	2	30	30	0

Analysis of gender breakdown (based on headcount) – non-audited information
Directors

	Male	Female
Executive*	6	3
Non-executive	6	1
Total	12	4

*Please see the list of executives from page 42 (includes those members of the joint team seconded to the Trust but employed by Somerset Partnership NHS Foundation Trust.

Other senior managers (all employees (excluding directors) at band 8 and above)

	Male	Female
Medical consultants + GPs	152	99
Senior managers (all band 8+ staff)	55	111
Total	**207**	**111**

Other employees

	Male	Female
Medical (training and career grade)	114	140
All other staff	698	3061
Total	**812**	**3201**

We welcome the requirement for UK organisations to report their gender pay gap. This is a good opportunity to understand and address the root causes of gender inequality in our society, and we are looking at how we can best do this in the local NHS. At Musgrove men and women are paid equally for the same jobs, but we do have a greater number of men in higher paid jobs and a greater percentage of women in lower banded and part time roles, which has created a gender pay gap.

We will be examining more closely the drivers behind the pay gap and looking at what actions we can take to improve the position. There is a national challenge to attract more women into medicine and other higher paying roles and more men into care roles so that talent guides career choices, not gender stereotypes, and we will continue to do what we can to address this.

The Trust plans to take further analysis in the coming months in order to understand the potential causes for the pay gap seen for 2016/17 and the ways of mitigating these causes. This will include looking at other acute trusts' gender pay gap submissions and analysis of how we have changed when looking at the period for 2017/18. In line with national guidance, the data for 2017/18 will be published on our website by April 2019. You can read our full gender pay gap report on our website at: http://www.tsft.nhs.uk/media/544532/TST-Gender-Pay-Gap-report-2016-17.pdf

Employee costs – audited information

	2017/18			2016/17		
	Total	Permanent	Other	Total	Permanent	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	147,461	145,872	1,589	140,265	138,565	1,700
Social security costs	14,098	14,098	0	13,498	13,498	0
Pension cost - defined contribution plans employer's contributions to NHS pensions	17,768	17,768	0	16,909	16,909	0
Pension cost - other	0	0	0	7	7	0
Other post-employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	96	96	0	431	431	0
Temporary staff - external bank	0	0	0	0	0	0
Temporary staff - agency/contract staff	8,793	0	8,793	7,846	0	7846
Recoveries in respect of seconded staff	(520)	(520)	0	(375)	(375)	0
Total gross staff costs	**187,696**	**177,314**	**10,382**	**178,581**	**169,035**	**9,546**

Sickness absence data and staff wellbeing – audited information

Figures Converted by Department of Health and Social Care to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2017	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
3,836	32,111	8.4	1,400,252	52,092

Health and safety

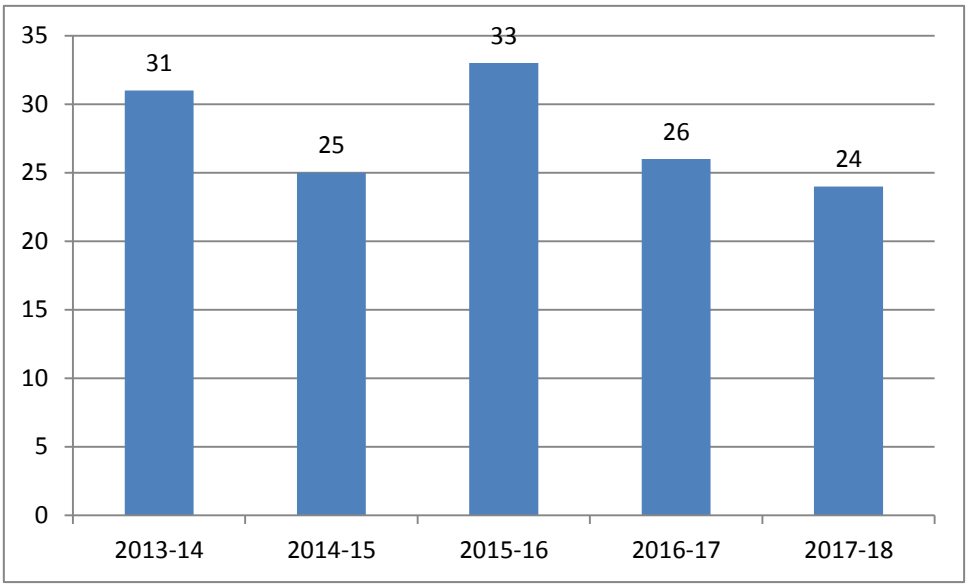
There continues to be a positive health and safety culture within the organisation and this is recognised by external regulators such as the Health and Safety Executive. The Trust's Health and Safety Committee and the Safety Environment and Advisors Group (SEAG) are effective meetings that ensure structures and processes are in place to successfully manage health and safety. Safety topic leads report to SEAG either directly or via specialist safety meetings such as the Fire Safety Committee. SEAG is chaired by the health and safety advisor who is responsible for ensuring that a structure is in place to manage the health and safety functions for the 24 topic leads that report into it. This includes policy consultation, development and approval, monitoring of policy implementation plans, policy monitoring and action plan updates. This work schedule aligns with the Quality Assurance Committee (QAC). Policies are in place for health and safety related topics along with a robust system for policy monitoring. This reports in to the SEAG work schedule.

Incidents reported to the HSE under RIDDOR

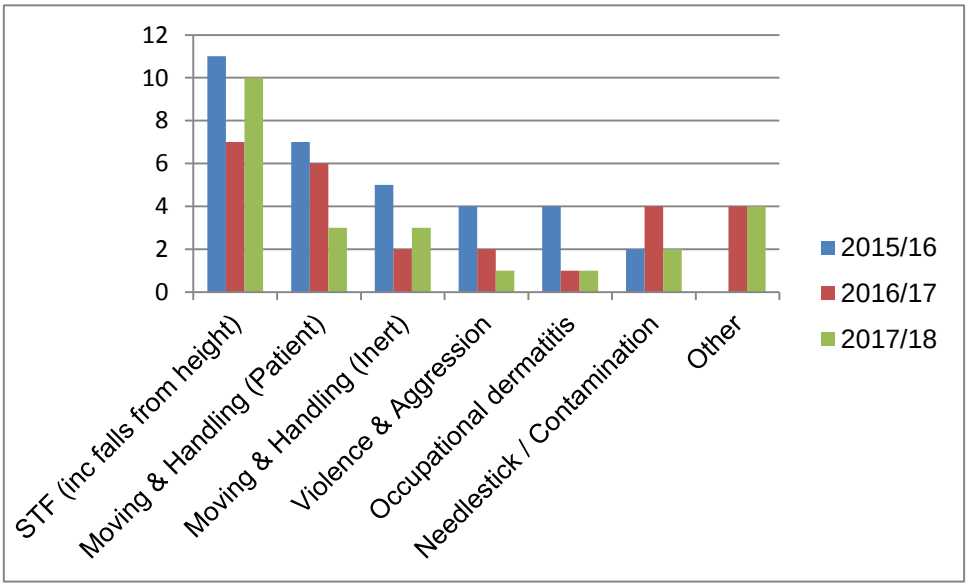
The Reporting of Injuries, Diseases and Dangerous Occurrences Regulation (RIDDOR) requires the Trust to report deaths, certain types of injury, some occupational diseases and dangerous occurrences that 'arise out of or in connection with work'. An annual RIDDOR report has been prepared and considered in the relevant fora. All RIDDORs are fully investigated and monitored. An overview of all RIDDORs is a standing agenda item on the safety committees. During 2017/18, the Trust reported 24 incidents to the Health and Safety Executive as detailed in the table below. This is a slight decrease from the 26 incidents during 2016/17. Of the 24 incidents, six were classified in the major incident category due to the nature of injuries that were sustained.

The following two tables are an extract from the annual report and give an indication of the total number of RIDDORs year on year and breakdown by cause.

Number of RIDDOR reports made to the Health and Safety Executive 2013/14 - 2017/18



Comparison of RIDDORs by cause 2015/16 - 2017/18



Counter fraud

Taunton and Somerset NHS Foundation Trust supports the NHS Counter Fraud Authority strategy that aims to reduce fraud within the NHS. We are committed to the prevention, detection and investigation of any such allegations and will seek to apply criminal, disciplinary, regulatory and civil sanctions where allegations are upheld. This includes the recovery of identified losses to ensure that NHS resources are used for their intended purpose - the delivery of patient care.

The Trust employs a counter fraud manager who conducts both proactive and reactive work to ensure that resources are not wrongfully diverted from patient care and there is a robust *anti-fraud, bribery and corruption policy* in place. All colleagues, contractors, vendors and patients are encouraged to report concerns to the Trust's local counter fraud manager or NHS Counter Fraud Authority.

Support for colleague health and wellbeing

The Trust works hard to look after its people and to keep them well. There is an employee assistance programme provided by Right Management Workplace Wellness which offers around the clock access to free and confidential advice and support for all staff. The workplace wellness team helps colleagues to proactively identify, plan and manage life events and helps them to stay in control, happy, healthy and fully focused on life and work. The Trust actively participated in Wellbeing Month in March to support colleagues in taking care of themselves, which in turn helps them to take better care of our patients.

Staff policies and actions applied during the financial year

The Trust's *recruitment and selection policy* ensures that full and fair consideration is given to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities. This is further enhanced by the Trust's *special leave policy* and *probationary period policy*, which have specific provisions to ensure that the needs of disabled persons are taken into account. Such policies apply to those who become disabled persons during the year, and the Trust is also compliant with the Equalities Act, which requires the provision of tailored measures to ensure that the needs of disabled employees are met. Many of the Trust's policies in regard to training, career development and promotion make no specific provisions for employees with disabilities. However, all employees are treated equally, and provisions are made for reasonable adjustments where required.

We work hard to engage our people in all that we do. Our executive and non-executive directors, as well as our governors, visit areas across the hospital to hear feedback from staff directly. Also, the Trust's Chief Executive encourages colleagues to share their feedback honestly and easily and there are regular drop-in sessions for colleagues to meet with the executive director team. A variety of direct and confidential communication channels are provided through the intranet, email and paper forms. Employees are provided with information on matters of concern to them. There are a range of communication and engagement tools that are utilised:

- A weekly staff bulletin, managers' briefing, Board briefing and governors' briefing.

- Executive director drop-in sessions.

- A team brief (with key strategic messages and operational performance) published on a monthly basis, key points from which are presented to colleagues (all of whom are invited) by the executive directors and dialogue encouraged.

- Urgent and important notices are sent by email to all colleagues.

- The use of social media as a form of interaction and communication (including Facebook and Twitter).

- Sharing information on the intranet, on which there is a comprehensive combination of organisational news, publications, database of policies and patient information, departmental information and information about colleague benefits. Some questionnaires are also hosted in this way.

The Trust takes concerns raised by colleagues and patients very seriously and has processes in place to enable staff to raise concerns without fear of reprisal, further information about this is available on the Trust's intranet pages. We aim to create a culture where colleagues, patients and carers are able to speak out when concerned about safety, quality or how we are demonstrating our values.
We know there will be occasions when we don't get things right; which is why encouraging colleagues and patients to raise concerns openly as part of normal day-to-day practice is an important part of improving the quality of the service we provide, patient safety and experience.

In 2016/17, the Trust appointed freedom to speak up guardians and they play a key role in helping to raise the profile of raising concerns. Colleagues can confidentially speak to them for advice and support in relation to concerns they have about patient safety and/or the way their concern has been handled. They help to foster an environment that is open and honest and to support a culture where colleagues feel comfortable about raising concerns and issues, no matter how big or small. During 2017/18 the freedom to speak up guardians have been raising awareness of their role across the Trust.

Staff survey

Colleague engagement continues to be a key priority for the Trust. Engagement is measured through the internal pulse check survey, which asks 13 questions to identify how colleagues feel about their line manager and key areas of engagement. The pulse check survey includes the two staff friends and family questions, asking staff if they would recommend to their friends and family the Trust as a place to work and as a place to have care or treatment. In addition, the annual NHS staff survey is used to measure engagement.

The Trust's top and bottom performing staff survey results are as follows, with comparator information against last year and against the national average:

Response Rate				
	2016/17	**2017/18**		**Trust improvement / deterioration** (%)
	Trust	**Trust**	**Benchmarking group (trust type) average**	
Rate	48%	40%	44%	Deterioration (8%)

Top 5 ranking scores				
Question	**2016/17**	**2017/18**		**Trust improvement / deterioration** (%)
	Trust	**Trust**	**Benchmarking group (trust type) average**	
KF10. Support from immediate managers	3.78	3.85	3.74	Improvement
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.98	3.99	3.75	No change
KF9. Effective team working	3.78	3.83	3.72	No change
KF5. Recognition and value of staff by managers and the organisation	3.52	3.56	3.45	No change
KF18. Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	48%	48%	52%	No change
Bottom 5 ranking scores				
Question	**2016/17**	**2017/18**		**Trust improvement / deterioration** (%)
	Trust	**Trust**	**Benchmarking group (trust type) average**	
KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	49%	43%	45%	Deterioration (6%)

KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	18%	16%	15%	Deterioration (2%)
KF23. Percentage of staff experiencing physical violence from staff in the last 12 months	2%	2%	2%	No change
KF24. Percentage of staff/colleagues reporting most recent experience of violence	68%	67%	66%	Deterioration (1%)
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month.	92%	91%	90%	Deterioration (1%)

In 2017/18, the Trust invited all colleagues to participate in the survey and responses were received from 1746 (40%). This is below the average response rate of 44% for 2017 and lower than the Trust's 2016 response rate of 48%. The completed responses are representative of the makeup of the organisation, making the results statistically valid.

The NHS staff survey measures overall engagement by looking at three areas:

- The willingness to recommend the Trust as a place to work and to receive care.
- The level of motivation at work.
- The ability to contribute to improvements at work.

The scoring methodology uses a weighted average where if every colleague answered "strongly agree" to all questions, the overall score for the Trust would = 5. If every colleague answered "strongly disagree" to all questions, the overall score for the Trust would = 1. The overall score for our Trust in 2017 was 3.91, which is an increase compared to 2016, and sees the Trust being ranked the highest (best) 20% of all acute trusts.

Future priorities and targets

The Trust's overall colleague engagement score has improved on last year and was ranked within the top 20% of acute trusts in 2017, and we are very pleased that colleagues have reported that their motivation at work has significantly improved.

The Trust is in the top five trusts in the south of England for the number of colleagues who said they would recommend the hospital as a place to work or have treatment. The Trust is also in the top 20% in England for support being available to colleagues from immediate managers, effective team working and recognition when they do a good job. Of the bottom five scores, three are benchmarked as being within the national average for acute trusts, only two are ranked as below average, with one of these having shown improvement.

Some of the areas where we have done less well include the reporting and experiencing of bullying, harassment, physical violence and reporting of near misses or incidents. We will be developing an action plan to specifically target these issues, but in the meantime we have already put training in place to ensure colleagues are equipped to support patients with mental health issues. We are training acute colleagues to de-escalate challenging situations and where this may not work how to keep themselves and the patient safe. Focus groups were run last summer at the hospital to look in depth at some of the issues underlying the responses last year and we are now beginning to implement our plans – such as specialist training sessions for colleagues, which help our acute colleagues to draw on the expertise within the alliance to deal with situations that are becoming more frequent.

The Trust is currently developing a *people strategy* jointly with Somerset Partnership NHS Foundation Trust and will ensure that the key themes and actions arising from the staff survey are addressed as part of its implementation.

Expenditure on consultancy

The Trust spent £0.2m on consultancy during the financial year. This expenditure was mainly on well led and workforce reviews (£0.06m), business development for the Somerset Cancer Register (£0.04m) and estate valuation (£0.04m).

Off-payroll arrangements – audited information

The Trust has a robust policy in place in respect of any off-payroll arrangements. In each case, the Trust's Chief Executive, or their delegated deputy, reviews and approves the cost, duration and purpose of any off-payroll arrangements. This is reviewed on a weekly basis.

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months

No. of existing engagements as of 31 March 2018	0
Of which…	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four and more years at time of reporting.	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018.	5
Of which:	
No. assessed as within the scope of IR35.	5
No. assessed as not within the scope of IR35.	0
No. engaged directly (via PSC contracted to Trust) and are on the Trust's payroll.	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review.	5

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed board members and/or senior officials with significant financial responsibility during the financial year. This figure includes both off-payroll and on-payroll engagements.	4

Exit packages – audited information

Foundation trusts are required to disclose summary information of their use of exit packages agreed in the year. The table below discloses all exit packages agreed in year including those payable to senior managers.

	2017/18			2016/17		
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	0	14	14	0	21	21
£10,000 - £25,000	1	1	2	1	2	3
£25,001 - £50,000	0	1	1	2	0	2
£50,001 - £100,000	0	0	0	1	2	3
£100,000 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
Etc.	0	0	0	0	0	0
Total exit packages by type	1	15	16	4	25	29
Total resource cost	£22,000	£74,000	£96,000	£187,000	£244,000	£431,000

The table below details the number of non-compulsory staff departures which attracted an exit package in the year and the values of the associated payments. The table has been prepared on exit packages agreed during the year irrespective of the actual date of accrual or payment.

	2017/18		2016/17	
	Payments agreed Number	**Total value of agreements**	**Payments agreed Number**	**Value of agreements**
Voluntary redundancies including early retirement contractual costs			0	
Mutually agreed resignations (MARS) contractual costs			5	£115,000
Early retirements in the efficiency of the service contractual costs			0	
Contractual payments in lieu of notice	15	£48,000	20	£129,000
Exit payments following employment tribunals or court orders			0	
Total	15	£48,000	25	£244,000
Of which: *Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary*	0		0	

NHS Improvement's *single oversight framework*

NHS Improvement's *single oversight framework* provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care.
- Finance and use of resources.
- Operational performance.
- Strategic change.
- Leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The *single oversight framework* applied from quarter 3 of 2016/17. Prior to this, Monitor's *risk assessment framework (RAF)* was in place. Information for the prior year and first two quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

The Trust has been placed in segment 3 under the new *single oversight framework*. This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on NHS Improvement's website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the *single oversight framework*, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017/18 scores				2016/17 scores	
		Q1	Q2	Q3	Q4	Q3	Q4
Financial sustainability	Capital service capacity	4	4	3	3	3	4
	Liquidity	4	4	4	4	4	4
Financial efficiency	I&E margin	4	4	3	4	4	2
Financial controls	Distance from financial plan	1	1	1	3	1	1
	Agency spend	1	2	3	3	2	3
Overall scoring		3	3	3	3	3	3

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Taunton and Somerset NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Taunton and Somerset NHS foundation trust and of its income and expenditure, total recognised gains and losses 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 and Social Care's Group Accounting 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 and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepare the financial statements on a going concern basis.

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 him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Peter Lewis, Chief Executive, 24 May 2018

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable 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 Taunton and Somerset NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Taunton and Somerset 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

The Trust has identified an executive director with responsibility for progressing risk management in the organisation. The Chief Nurse has clearly defined risk management responsibilities and is supported by the Head of Integrated Governance. As from 1 April 2018, executive responsibility for risk management will transfer to the Director of Governance and Corporate Development. The Chief Operating Officer has overall accountability for the day to day delivery of risk management activity within the clinical directorates. Responsibilities for risk management are clearly defined within job descriptions for all of these roles.

The Trust's governance support unit is responsible for providing appropriate training, support and guidance to enable all managers to carry out their risk management responsibilities. Specific training courses on risk management for managers, risk assessment, incident management and investigation are supported by a corporate induction and mandatory update programme covering all regulatory requirements.

The Chief Nurse and Chief Operating Officer are key members of the Trust's Executive Committee, where the risk register is reviewed monthly to ensure operational risks are being adequately controlled.

The Chief Nurse chairs the Trust's key operational management group for governance, the Quality Assurance Committee (QAC), and the Head of Integrated Governance is a member of this committee. The QAC meets monthly to monitor progress with corporate and operational plans and receive assurance reports and improvement plans from nominated leads on all regulatory requirements in accordance with its reporting schedule.

The Trust's Serious Incident Review Group meets regularly to share issues raised following incidents, complaints, concerns and claims, along with information from other key sources, such as morbidity and mortality reviews. This enables sharing of good practice and lessons learned via directorate governance structures and allows for direct input into the Trust's improvement programme.

The Audit Committee has responsibility for monitoring the effectiveness of the Trust's risk management systems and for reviewing and challenging the organisation's risk appetite and maturity.

The risk and control framework

The Trust's *governance policy* details how risk will be identified, evaluated and managed. It gives details of the monitoring arrangements and the authority for decision-making through identified posts or committees. The main methods for the identification of risk are:

- Review of compliance with key standards, for example the Care Quality Commission (CQC) registration requirements, and legislation such as the Health and Safety at Work Act (1974).

- Executive review of annual and strategic objectives to identify potential risks to meeting those objectives.

- Local risk assessment at departmental level, feeding up to divisional risk registers.

- Facilitated risk identification sessions at various levels in the organisation.

- Incident reporting and complaints information.

- Information from external sources such as the Care Quality Commission's (CQC) inspection, audits and patient and staff surveys.

All risks are assessed and evaluated using a standard form and scoring system, allowing direct comparison. From this evaluation, risks are categorised into one of three accountability levels, and responsibility for the control and monitoring of the risk is allocated to the department, the directorate or the Trust's executive team, depending on the level identified. Responsibility for completing actions is allocated to an individual manager, with monitoring carried out by the relevant directorate committee or Trust executive director. The three accountability levels are set based on the Trust's risk appetite, which is regularly reviewed by the Board.

Risk identification is linked to the setting of organisational objectives, as detailed in the Trust's board assurance framework. Capital planning includes an assessment of risk issues, and spending is prioritised on a risk basis. All papers considered by the Board are referenced to the risks they are aimed at addressing. The board assurance framework links to the significant risks that may affect the Trust achieving its objectives, how they are currently controlled and what sources of assurance the Board has that the risks are being managed appropriately. It also details action that is necessary to reduce the risks or improve sources of assurance, with prioritisation based on the standard Trust risk evaluation process. Information and data security risks are identified and managed through the Trust's risk assessment and incident reporting processes. The Trust has established an Information Governance Steering Group to monitor this process and provide assurance on the systems in place for managing information risks.

As part of its ongoing commitment to risk management, the governance support unit develops an annual plan, monitored by the Governance and Quality Committee that includes key risk management objectives. The Trust's internal work plan is linked to key risks.

Assurance on compliance with Care Quality Commission (CQC) registration requirements, along with other key regulatory requirements, is provided to the Governance and Quality Committee via the work of the Quality Assurance Committee (QAC). The QAC reviews the assurances in place for all requirements in line with an annual plan, providing regular updates to the Governance and Quality Committee.

Taunton and Somerset NHS Foundation Trust is fully compliant with the registration requirements of the CQC.

The Trust involves its key stakeholders in managing risks which impact on them in a variety of ways and the Council of Governors has a key role in supporting and challenging the Board.

The Trust's key risks for 2017/18 were:

- Financial challenges and failure to achieve control total.

- Operational pressures having an impact on the quality of care provision and the delivery of the Trust's operational performance standards (RTT, 62 day cancer, diagnostic waiting times and A&E).

- Management of demand across the system, particularly in emergency care.
- Age of the estate.
- Key clinical staffing vacancies, particularly in nursing.
- Recruitment, training and retention of key clinical staff.

In 2018/19 and into the longer-term, there are a number of similar, key strategic risks facing by Taunton and Somerset NHS Foundation Trust relating to financial, operational and staffing challenges across the Somerset health and care system, including cash flow and the ageing estate. The Trust will continue to look at how these risks can be mitigated through the alliance with Somerset Partnership NHS Foundation Trust and by working more closely with other partners in Somerset and in neighbouring counties and as part of the sustainability and transformation plan (STP).

There are no significant risks relating to compliance with the NHS foundation trust condition four relating to corporate governance. As part of its internal audit plan, the Trust undertakes reviews of its governance and risk management arrangements.

Also, in 2017 the Trust commissioned Deloitte LLP jointly with Somerset Partnership NHS Foundation Trust to undertake an independent review of its governance arrangements using NHS Improvement's well-led framework. In preparation for the review, which commenced in September 2017, the Trust completed a self-assessment aligned to Monitor's 2015 well-led framework. NHS Improvement's revised 2017 well-led framework was, however, subsequently published and the review has therefore been aligned to take account of the new key lines of enquiry. Deloitte used the following methodology in their assessment:

- Reviewing the Trust's self-assessment.
- Undertaking 1.5 hour interviews with Board members during September and October 2017.
- Undertaking 1 hour interviews with senior members of staff during September and October 2017.
- Observing a range of Board, committee and directorate meetings during September and October 2017.
- Undertaking visits to a range of frontline and support service areas in October 2017.
- Distributing and analysing online surveys to Board members, colleagues and governors.
- Carrying out 30 minute interviews with a range of external stakeholders.

- Following discussion with the Trust, Deloitte did not undertake any staff or Governor focus groups. Some discussion with staff and governors did take place as part of 1:1 interviews, service visits and meeting attendance.

The recommendations from the review have been captured into an action plan agreed by the Board with timescales for completion. An update on progress will be presented to the Board in September 2018.

The Trust has further developed its risk management processes to ensure that relevant and up to date risk information is available at all key meetings, ensuring that decisions are based on robust assessments of risk. The Trust has an open and fair culture, encouraging incident reporting to enable the hospital to learn and improve as part of its core business.

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 that all the organisation's obligations under equality, diversity and human rights legislation are complied with.
The 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.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments, and carbon delivery plans are in place, in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the Trust's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

<u>Review of economy, efficiency and effectiveness of the use of resources</u>

An important part of the Trust's responsibility is that the Trust assesses and reviews the financial sustainability of the organisation. As such the Trust has considered the scale of the financial challenges it is facing over the next 12 month period. As a consequence it is clear there is material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. This specifically relates to the impact on the cash position of the Trust in 2018/19. However, after making enquiries, the directors have a reasonable expectation that Taunton and Somerset NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

Throughout the year the Finance Committee and the Board have closely monitored the financial position and the impact of the significant operational pressures on the delivery of the Trust's financial plan.

The Trust ensures economy, efficiency and effectiveness through a variety of means, including:

- A robust pay and non-pay budgetary control system.
- A suite of effective and consistently applied financial controls.
- Effective tendering procedures.
- Continuous service and cost improvement.

The Trust benchmarks efficiency in a variety of ways, including the national reference costs index and by comparison with the annual surpluses generated by all foundation trusts.

Information governance

The Trust had one serious information governance incident that was reported to the Information Commissioner's Office (ICO). Survey data which was being processed by a 3rd party was not anonymised when sent to another 3rd party processor. Appropriate action was taken and the data was deleted and a review undertaken. The ICO confirmed that no action would be taken as appropriate technical and organisational measures were taken against the unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data. The incident appeared to have been contained, and remains contained, so it is unlikely any significant detriment will result from it.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality reports for each financial year. NHS Improvement (in exercise of those powers conferred on Monitor) 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 Chief Nurse leads the development of the annual quality report. Key stakeholders are involved in the development of the report. The development of the priorities and indicators was based on all types of patient feedback over the year, with the Council of Governors approving the final list of priorities.

The Head of Integrated Governance, supported by the governance support unit, clinical information analysts, clinical audit facilitators and other specialists, has coordinated the preparation of the quality report. Controls are in place to ensure that all the Trust's employees have the appropriate skills and expertise to perform their duties. This includes the provision of relevant training and helps to ensure the accuracy and reliability of data collected and prepared by employees and which is used to assess the quality of the Trust's performance.

The quality metrics included in the report have been regularly reported through Trust governance structures, including the Governance and Quality Committee, Trust Board and Council of Governors where appropriate.

Data quality issues are addressed through the Trust's information governance systems in line with its *information and data quality policy.*

The metrics include key measures developed with the Trust's principal commissioners, the Somerset CCG, to provide them with assurance that the Trust is providing high quality care. Additional measures relating to patient experience are provided by the monthly assessments that the Trust has established, overseen by the Trust's Patient Experience Committee.

The quality report presents a fair and balanced view of the activities of the Trust, based on data which is subject to rigorous quality control as well as internal and external audit. The data used to inform the quality report is overseen by the Trust's Information team and the governance support unit, in compliance with the policies and procedures in place to ensure the quality of data.

The Trust has a robust process for the measurement of performance, which triangulates quality, workforce and financial indicators. The Trust's approach is known as the PAF (performance assurance framework) process. Each directorate has its own PAF, split into four areas: patients, people, operational delivery and finance / improvement. This is similar to a balanced scorecard approach, in line with the recommendations of Lord Carter's recent review of NHS services.

The PAF is reviewed monthly. The process involves the directorate manager, directorate clinical director, representatives from HR, finance, the operational performance and information teams and others. Each directorate reports on numerous indicators across the four PAF domains. These include all key clinical, operational and financial targets to ensure that the NHS mandate, NHS constitution, local quality and financial targets are met.

PAF meetings (and indeed Trust Board meetings) begin with a patient story to put the work of the directorate into a patient context and bring the indicators "to life" in relation to patient care. Where indicators are red, these are specifically discussed, as are areas of good practice. Selected early warning indicators are also analysed with a view to prevent them deteriorating. The PAF meetings also include a review of all high scoring risks (i.e. risks scoring 12 or above) to ensure the Trust is appropriately sighted upon the risks to service delivery, including access times, quality, workforce and finance. The Trust faces risks to its performance in a number of key areas, especially in relation to high levels of demand, but continues to take action to mitigate these risks wherever possible. Along with its regularly reviewed business continuity plans, this allows the Trust, as far as possible, to respond appropriately to uncertainty.

The purpose of the PAF process is to enable effective triangulation of performance, finance and quality issues and to take the necessary remedial action to improve them all. An aggregated PAF is presented to the Board on a monthly basis, highlighting key areas of good and poor performance. The Board uses the information presented at the PAF to direct work and resources to the remediation of issues and the continuing improvements in those areas of quality and productivity where performance is good. The Trust monitors performance against numerous local and national targets through the PAF process as described above.

One of the areas included on the PAF is elective waiting times. Elective waiting lists are validated by a dedicated data quality team on a daily basis to ensure the correct patients are being booked (i.e. in priority and chronological order) and that reported performance is accurate. Booking teams and admin staff also contribute to the validation of waiting lists. Performance against RTT and pending list targets is reviewed in weekly meetings with each specialty team where any data anomalies are identified and fed back to the data quality team for further investigation.

Review of effectiveness

As Accountable 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 trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in 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 and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The board assurance framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. The most significant assurance on delivery of quality that informs my review is the ongoing assurance programme overseen by the Governance and Quality Committee. My review is also informed by:

- Feedback from the Care Quality Commission (CQC) inspection in 2017 and the Trust's assurance process for monitoring levels of compliance with CQC standards of quality and safety.
- A review of compliance with NHS Improvement's *single oversight framework*.
- Programme of work undertaken by the Trust's internal auditors.
- Clinical audit annual programme, including relevant national audits.
- Deanery and college inspections.

- National reporting and learning system incident report.

In assessing and managing risk, the Board and its sub-committees have a substantial role to play in reviewing the effectiveness of the system of internal control as follows:

> Trust Board: Through the review of the Trust's corporate risk register, board assurance framework and key performance indicators.
>
> Audit Committee: Through the review of the internal audit programme of work, receipt of reports from external audit, and assurances gained through management reviews requested by the Audit Committee.
>
> Governance and Quality Committee: Through the review of the Care Quality Commission (CQC) registration process, confirming the process by which the standards have been assessed, through the review and management of the Trust's risk register and quality assurance processes and the development of the *governance policy* and through oversight of the governance support unit's annual plan of improvement work.

<u>Conclusion</u>

No significant control issues have been identified.

……..
Peter Lewis, Chief Executive Date: 24 May 2018

Taunton and Somerset NHS
NHS Foundation Trust

Quality Report

2017-18 – incorporating the Quality Account

Taunton and Somerset NHS
NHS Foundation Trust

Quality Report 2017-18 – incorporating the Quality Account

CONTENTS

QUALITY REPORT 2017/18 – INCORPORATING THE QUALITY ACCOUNT

PART ONE

FOREWORD FROM THE CHIEF EXECUTIVE

Having become Chief Executive earlier this year, I am proud to lead an organisation which continues to make significant improvements to the quality of care. Putting together the Quality Account gives the Trust the opportunity to look at the successes and improvements we have made as well as the areas where we need greater focus in the future.

We were pleased that the Care Quality Commission (CQC) gave us an overall rating of 'Good' when they inspected us in August 2017. The review focused on four core service areas – end of life care, urgent and emergency services, surgery and outpatients. The CQC found a number of examples of outstanding practice in these areas. This is well-deserved recognition for our staff, who, on a daily basis, go above and beyond the call of duty to ensure that patients are treated with compassion, kindness and respect. The complete ratings are detailed in the table below:

Ratings for Musgrove Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017
Medical care (including older people's care)	Requires improvement May 2016	Good May 2016	Outstanding May 2016	Good May 2016	Good May 2016	Good May 2016
Surgery	Good ↑ Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017
Critical care	Requires improvement May 2016	Good May 2016	Outstanding May 2016	Good May 2016	Good May 2016	Good May 2016
Maternity	Requires improvement May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016
Services for children and young people	Requires improvement May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016	Good May 2016
End of life care	Good →← Dec 2017	Requires improvement →← Dec 2017	Good →← Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017	Good ↑ Dec 2017
Outpatients	Good Dec 2017	Not rated	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2016	Good Dec 2017
Overall	Requires improvement →← Dec 2017	Good →← Dec 2017	Outstanding →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017	Good →← Dec 2017

The CQC reported that since the hospital's previous inspection in 2016, significant improvements had been made. The CQC recognised the trust's commitment to high quality care, and highlighted our focus on improvement.

The Trust identifies a series of quality priorities each year. These are selected with input from staff, governors, members and patient representatives before being signed off by the Board of Directors. We made substantial progress against our quality priorities for 2017/18 as described within our report. Our quality priorities for 2018/19 are:

- Learning from deaths
- Safer care
- Mental health and holistic care
- Patient experience
- Right care, right time, right place
- Staff retention and wellbeing

Further information on achievements and progress made in relation to these priorities is found later on in this Quality Account.

There have been numerous quality improvements over the last year. Many of these have been led or supported by the Trust's dedicated improvement team, which spearheads improvement initiatives across all aspects of the Trust's work. Led by a clinical director, the improvement team comprises experts in project management, thus ensuring that benefits can be realised and sustained. All of these colleagues have been trained in improvement science and are able to use their skills to equip clinicians and managers to make significant improvements to services. This year, the improvement team launched a series of improvement boards, which are coordinating quality improvement projects across the Trust.

Of the numerous successful improvements over the last year, one notable example concerns the introduction of the Trust's new "Integrated Front Door" (IFD) service. This new approach to improving the experience of patients arriving at the Emergency Department has helped us control waiting times and patient flow throughout the rest of the hospital by reducing admissions.

The IFD is a good example of how the Trust is increasingly working with partners from outside the hospital. The IFD service employs 18 GPs, who can use their expertise to ensure that patients presenting at the hospital are seen in the most appropriate way. This allows for the hospital's emergency doctors to focus their time on those patients who are more seriously ill. The Emergency Department has also been refurbished this year, with quality improvements including more paediatric assessment rooms and a new Mental Health assessment facility.

The Trust continues to explore a closer alliance with Somerset Partnership NHS Foundation Trust, the provider of community and mental health services in

Somerset. One example has been the creation of a liaison psychiatry service, which began in January 2018. This new service will assess and treat patients who arrive at the hospital with mental health needs, many of whom have previously had to wait in inappropriate settings to receive good care. The service is a significant expansion of what existed before, and operates across the whole of Somerset.

There have been concerted efforts this year to improve the way we discharge patients, and to make sure that we help people return home earlier and more safely. The “Home First” initiative helps to achieve this. Average hospital stays have been reduced by half a day per peson, allowing people to return home, or go to a community hospital, for their assessment and rehabilitation planning, rather than waiting in hospital.

The Trust has been recognised in a number of awards for quality this year. The paediatric team won the Acute, Community and/or Primary Care Services Redesign Award at the HSJ (Health Service Journal) Awards in London for their programme to take their clinics to local GP surgeries so that children and their parents can benefit from a more convenient and less daunting environment.

The international Surgical Review Corporation declared Musgrove Park Hospital an international centre of excellence for bariatric surgery, making it the only hospital in the UK to have been reaccredited with this prestigious status.

The Maternity service won an HSJ Patient Safety Award, and was nominated for a prestigious national Butterfly Award for compassionate maternity care. Around the same time, the trust’s Mary Stanley birthing unit became operational 24/7 for the first time in ten years, a significant improvement, giving greater choice for parents-to-be in Somerset.

I hope you find the Quality Accounts interesting and informative. I would welcome any thoughts or feedback you would like to share.

The Trust has a mechanism in place to identify any guidance issued by the Secretary of State and act upon it appropriately. To the best of my knowledge and belief, the information in the Quality Account is accurate.

Signed……

Peter Lewis
Chief Executive

ABOUT US

Musgrove Park Hospital is part of Taunton and Somerset NHS Foundation Trust (TSFT).

We are an acute hospital in Somerset serving a population of over 340,000, as well as providing some specialist and tertiary services for the whole of Somerset with a catchment population of 544,000.

Each year the Trust, at Musgrove Park Hospital and at some community settings, sees in the region of:

- 48,000 patients admitted as emergencies
- 48,500 patients seen for planned care, either as an inpatient or on a day case basis
- 370,000 patients attending outpatient clinics
- 71,500 attending the Emergency Department
- 250,000 diagnostic imaging examinations
- 3,300 babies born in the Maternity Department
- 1,400 transfers to the trust's intensive care and high dependency units

The Trust had a turnover of £308.9m in 2017/18 (£299.9m in 2016/17). The hospital has 30 wards, nearly 600 beds, 15 operating theatres, a fully equipped diagnostic imaging department and a purpose built cancer treatment centre which includes outpatient, chemotherapy day care, radiotherapy and inpatient facilities. The Trust employs over 4,000 staff.

We are committed to providing the safest possible patient care, the best possible experience for patients and the most effective use of the resources we have.

PART TWO
PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

UPDATE ON QUALITY IMPROVEMENT PRIORITIES (QIP) 2017/18

In March 2017 the Trust Board agreed the following Key Quality Improvement Priorities (QIP) for 2017/18:

1. Care of frail elderly patients and those patients with dementia
2. Partnership working linked to the Sustainability and Transformation Programme work relating to new models of care
3. Safer Care
4. Improving processes for discharging patients from hospital
5. Improving the experience of acute services for people with mental health needs
6. End of Life Care
7. Improving Patient Experience for Inpatient and Outpatient Care, Linked to the Priorities for the Trust's Improvement Work

Producing a Quality Account is an opportunity for organisations to collect, review and analyse information relating to quality so that they can decide where improvement is needed, in such a way that it becomes part of core business. It can also help with benchmarking, or comparing ourselves, against other organisations. At Musgrove these processes are fundamental to our quarterly clinical quality review meetings with the commissioners and the development of agreed Commissioning Quality for Innovation targets (CQUINS) each year.

Based on the wide ranging evidence already available in the Trust about patient safety and care, and looking at our progress with last year's CQUIN targets, several quality topics were identified as having room for improvement or focus. These topics were developed with the help of the Patient Care Group.

QIP 2017/18 – Priority 1 - Care of frail elderly patients and those patients with dementia

Why this is important

The challenge of how the frail elderly are managed is one of the biggest clinical issues that acute hospitals face in the next decade. Over a third of all admissions are very frail, and they have increasingly complex medical, social and psychological issues. This makes managing length of stay and the consequent availability of beds particularly challenging.

What did we achieve?

Escalation

- The 5-day Older Persons Assessment and Liaison (OPAL) practitioner in Emergency Department was extended to 7-day in October 2017. There was an increase from two to four practitioners to expand the service – they have now seen a total of 2,718 patients since the service started and 1,484 patients in 2017/18, which is a 58% increase from the previous year. 53% of these patients have received a Comprehensive Geriatric Assessment. In total 35% discharged home directly from the Emergency Department by the OPAL practitioners.
- The OPAL unit has seen a total of 5,303 patients since opening and in 2017/18 saw 29% more patients than in the previous year, in part due to an increase in the OPAL bed base due to winter pressures.
- The length of stay in Medicine has been reduced for people aged 75 and over by 0.9 days.
- The Red Cross discharge service assisted 387 patients home in their first six months of operation.
- We are now reaching 80% of emergency admissions aged over 65 being screened for delirium on AMU and 90% of all patients with emergency admissions aged over 75 screened for dementia.

De-escalation

- The 5-day week Orthopaedic Liaison Service now has cross cover of medical staff resulting in a far more consistent service.
- A 5-day week Surgical Liaison Service has been initiated – this has resulted in a reduced length of stay by 0.55 days. The percentage of frail older patients having a geriatrician review following an emergency laparotomy has increased from 17% to 90%.
- A ‘Proactive care of the Older People undergoing Surgery’ (POPS) nurse practitioner started December 2017, with all patients aged over 70 with upper gastro-intestinal or colorectal surgery being assessed, if needed.

Transition

- A Comprehensive Geriatric Assessment (CGA) taking a patient's current medical issues, co-morbidities, social and psychological factors into account is now available in the Emergency Department via the OPAL practitioners and JETT (Joint emergency Therapy Team), the OPAL unit through the Geriatricians and JETT, and on the surgical (Upper GI and Colorectal) wards through a combination of medical staff and OPAL practitioners. Orthopaedic CGA are completed by medical staff and therapies. These assessments are a starting point in providing the same high level of care across all departments.

QIP 2017/18 – Priority 2 - Partnership working, linked to the Sustainability and Transformation Programme work relating to new models of care

The Somerset Transformation Programme (STP) sets out a number of priorities relating to new models of care, including the following that are directly relevant to Musgrove Park Hospital:

- Develop a consistent new model of urgent care across Somerset that focusses on integrating acute services, primary care and community urgent care.
- Redesign our acute front door to ensure a consistent, single access point for patients - integrating acute, mental health, primary / community services and social care and providing seamless access both in and out of hours.
- Focus on consistent implementation of Ambulatory Emergency Care pathways across the county.
- Use technology to replace traditional 'face to face' urgent care models.

Developments in these areas during 2017/18 are outlined below:

Develop a consistent new model of urgent care across Somerset that focusses on integrating acute services, primary care and community urgent care

During 2017/18 three different ways of supporting patients that need urgent care services have been developed. These are the Community Development and Liaison Practitioner role, Home First and the Supporting Care Homes project.

A Community Development and Liaison (CDL) Practitioner is currently being piloted, with an initial focus on the West Somerset area. The role helps link patients with local services and acts as a liaison with primary care for patients admitted as an emergency to Musgrove Park Hospital as well as patients being

admitted to community hospitals run by Somerset Partnership NHS Foundation Trust. The plan is for the CDL Practitioner to be involved at the start of the patient's admission to ensure continuity throughout the patient's period of recovery. The role is a conduit for community development, and a facilitator for sharing information between the various projects that are ongoing in this area. It will also help to identify any gaps in current services for future service development.

Home First is a Collaboration service between Taunton and Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust, Somerset Partnership NHS Foundation Trust, Somerset County Council and home care providers. Home First facilitates the discharge of Medically Fit for Discharge patients out of the acute trust. Patients receive an intensive period of reablement in three settings to promote independence and keep patients (for as long as possible) in their usual place of residence. Patients are identified by the Practice Development Forum / Multi-Disciplinary Team to either receive their assessment and reablement at:

- Home (Pathway 1) – the therapist will meet the patient at their home and carry out an assessment of reablement needs which a pathway provider will deliver (currently one of three Home Care Providers taking part in the pilot).
- Reablement Unit (Pathway 2) – for the West this is Bridgwater Community Hospital and for the East, Cookson Court and West Mendip Community Hospital. This is to enable the patient to receive an intensive period of reablement to allow them to safely go home. Patients can step down from Pathway 2 to Pathway 1.
- Residential / Nursing Home Reablement Facility (Pathway 3) – In the West this is Hamilton Park and in the East Sherborne Care Home. This is for more complex patients and the aim is provide a period of reablement that will allow the patient to return to their usual place of residence (home / care home). Patients can be stepped down to Pathway 2 and/or Pathway 1.

So far 764 patients have used the Home First service. Of the 694 patients discharged, 59% required no additional needs after reablement. The average age of patients using Home First is 81 years.

Supporting Care Homes is collaboration between care homes, primary care, palliative care, SWAST (South West Ambulance Service Trust) and community pharmacy. 20 care homes have been identified within the Somerset Clinical Commissioning Group area following review of the total number of contacts with SWAST and number of patients conveyed to an acute hospital. Visits are being set-up to care homes starting with those with high volume admissions, and those who are already working with us. Study days are currently being considered for

residential homes on Treatment Escalation Plan (End of Life care planning) and other pertinent clinical topics.

The Integrated Front Door (IFD): Like many other Emergency Departments (ED) in England, Musgrove Park Hospital is facing the 'perfect storm' of rising numbers of patients and increasing difficulty of recruiting permanent emergency medicine doctors. Faced with this challenge, Musgrove has chosen an innovative design to meet the needs of patients by delivering a modern solution for Somerset. The minors part of ED has been converted to an integrated front door, staffed by general practitioners and emergency nurse practitioners. Patients are able to be streamed between urgent and emergency care and to other services, such as the Psychiatric Liaison Team, using defined pathways for each stream. This ensures a targeting of resources to maximise value and patient experience.

There has been an increase in consultation and treatment rooms and the staffing model has changed markedly, with 18 GPs working as part of the service, ensuring GP presence 16 hours per day. There was significant investment in allied health professionals, including 11 emergency nurse practitioners to enable 24hr cover, an emergency care practitioner, two physiotherapists and a significant number of health care assistants. These changes have allowed ED doctors and other ED staff to concentrate on those patients who require care in the majors or resuscitation area of the department.

Prior to 'go-live', and using quality improvement methodology, a number of pilots were arranged to safely test the new model and measure the impact of the changes. Patient and staff feedback was used to inform the design of the model. Since 'go-live', performance has continued to improve, as has patient satisfaction. 152 patients completed a satisfaction questionnaire, of whom around half had used the ED before. Of those, 46% said they were seen and treated more quickly through the IFD than their previous service experience, 36% said both times they experienced very good service, and 15% said they received the same level of service with the IFD as before.

For children, the POPS (Paediatric Observation Priority Score) system has been introduced. This is a bespoke tool to assign acuity of illness to children and young people, and the version 2.0 app was developed in partnership with the original developers and the ED team at the Trust, specifically for the unique Taunton IFD.

Overall ED 4 hour wait compliance for the integrated front door has been consistently above 95% and supports overall department performance above 91% for the year to date, despite an 11% increase in attendances relative to the same period last year.

Use technology to replace traditional 'face to face' urgent care models

Changes to the model of information for care delivery are overseen by the Somerset Integrated Digital Record project. This is a nationally funded piece of work being developed by Black Pear with all the public care organisations in Somerset.

The technology has provided direct and seamless access to relevant patient information without recourse to other systems. Furthermore, it helps to eliminate the need for patients to fill in gaps in their care and medication history.

Implementation of the EMIS Viewer, enabling read only access to patient records (subject to patient consent at the point of care) in Somerset care settings, has demonstrated significant clinical benefits, improved patient care, support for Urgent Care and enabled clinical and administrative time to be recovered for other tasks. This has created the appetite for more, to access other clinical / care information from other care provider sources to further improve person / patient care.

There is the ambition and need to share wider health and social care provider records on people / patients across Somerset, subject to affordability, information governance and compliance with NHS Clinical Safety requirements. Once established, Somerset aims to link to other similar solutions in the region and to recognise Digital Roadmap and Sustainability and Transformation Programme footprints. This would also contribute to the national move to have a single (virtual) health and social care record, plus each patient to be able to view their record online.

Everything that we do now needs to contribute to the following objectives:

- Records largely paperless by 2020
- Records accessible to health and social care
- Records accessible in real time
- People / patients able to view and annotate a version of their health record online.

Once core health and social care providers are able to share information more effectively, it is aimed to open up services and care record interaction for patients. In line with this, the model will be extended by inviting other care providers to share their information and systems, including voluntary, third and private sector providers in Somerset and over the borders, which may include other GP practice systems, such as SystmOne by TPP.

The aspiration is to link to national target architecture services in order to send structured documents elsewhere, as well as to utilise national services. This will help deliver on the Somerset Sustainability and Transformation Programme (STP)

shared care record digital theme as well as improve the digital maturity status across the Somerset Digital Roadmap (SDR), allowing the Trust to better interact with regional and national services and solutions being developed.

Other models for supporting Urgent Care, such as Telehealth and Remote Assistance are being considered in the strategy review with Somerset Partnership NHS Foundation Trust. These will be detailed in next year's update.

QIP 2017/18 – Priority 3 - Safer care (Patient Safety Improvement Board)

Why is this important?

For the last few years the Trust has been focusing on a safety programme through the national Sign up to Safety programme. What has been clear from experience and learning is that it has facilitated bringing all the various safety work streams into one place in a multi-disciplinary forum. The work streams that were being overseen under this programme have mostly become well embedded in ongoing service monitoring and improvement with governance structures to support ongoing improvement initiatives. A new oversight and improvement group has been set up, the Patient Safety Improvement Board. This group will aim to have oversight of a select group of patient safety initiatives that are highlighted as needing support from the senior team and service improvement

What do we want to achieve?

Now that previous work streams are embedded as 'business as usual', the Patient Safety Improvement Board is reviewing the safety programme work streams to identify new priorities linked into the wider improvement work in the Trust. The plan will be to use the first few months of the year to analyse all the information we have from incidents, complaints, patient feedback and other sources to identify areas where further work is required, based on a review of themes. These themes will then be used to develop project plans which include clear aims for improvement and detailed action plans using some resource from the improvement teams to support using a standard improvement methodology to support improving practice.

How this will be measured and monitored?

As part of the preparation for each project, a set of measures will be developed to enable the work to be closely monitored. The exact nature of these measures will depend on the areas identified, but will include process measures focussing on quality control and outcome measures to ensure that the work we are doing is making the improvements we want.

How will this be reported?

The Patient Safety Improvement Board will form the basis of one of the work streams for improvement in the Trust. There will be five improvement boards overseeing the projects, of which patient safety will be one. The improvement boards will report on progress to the Trust's Executive Committee.

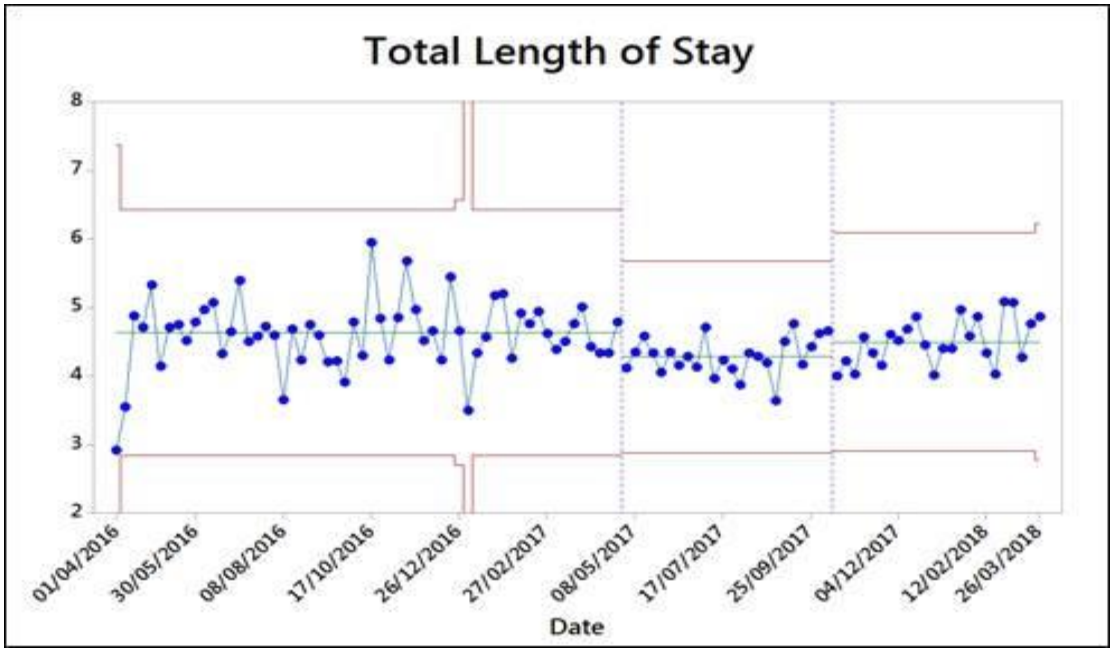
QIP 2017/18 – Priority 4 - Improving processes for discharging patients from hospital

Why is this important?

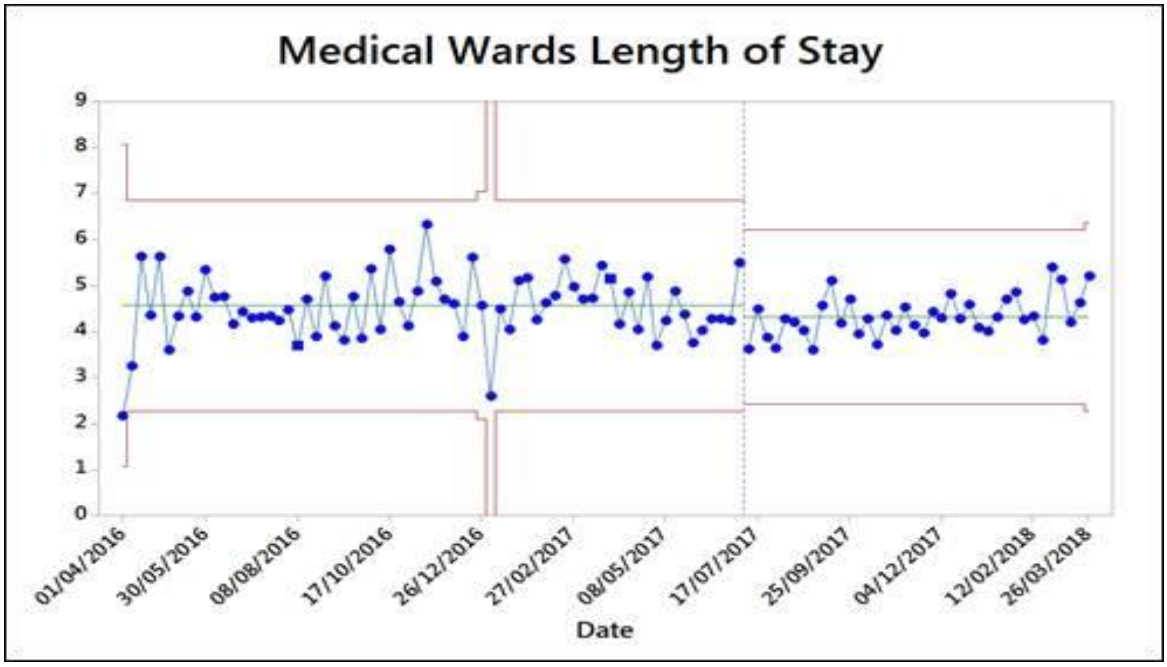
With the increasing demands placed on Musgrove Park Hospital, the need to improve the efficiency of the hospital, and, at the same time, enhance care for patients has never been more important. During the year 2017/18, the Trust has worked to improve the discharge of patients. This work will not only reduce the amount of time that patients have to wait for discharge in an acute hospital, but will also make the best use of the scarce resource of acute beds. We also know that patients who are delayed in hospital are increasingly vulnerable to decom-pensation, deterioration in their physical and mental health and more likely to fall or contract a hospital acquired infection. For all these reasons, we have worked to reduce any delays to patients who are cared for in our hospital.

What have we achieved?

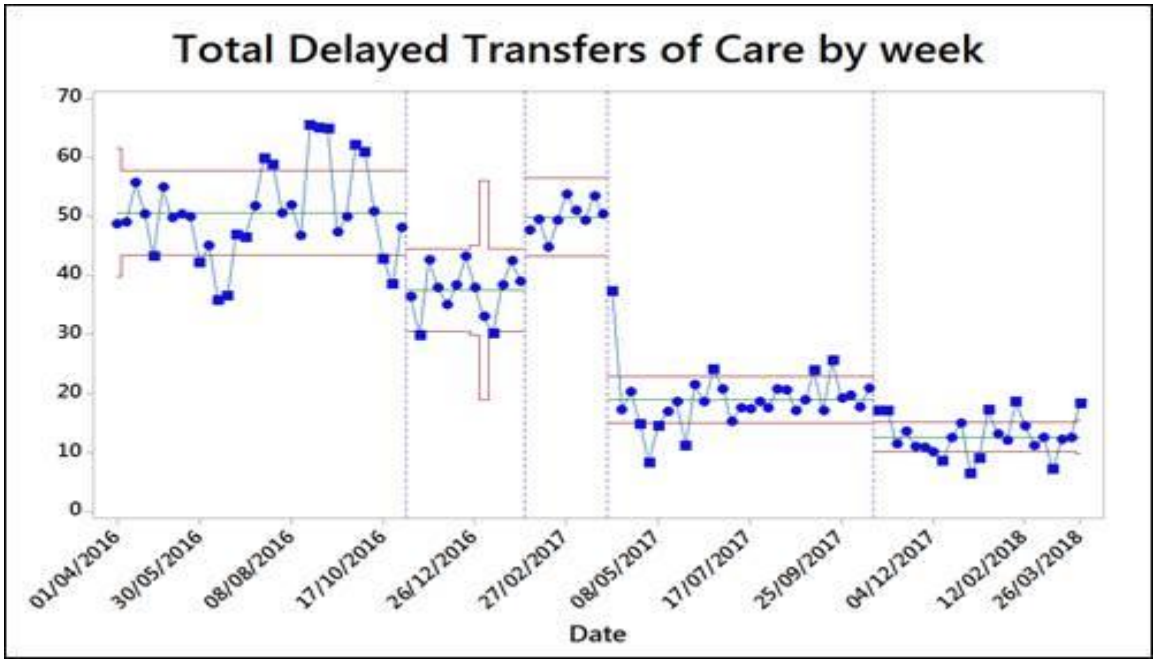
During the year we have consistently reduced the length of stay in the hospital from 4.64 days to 4.5 days (0.14 days)



In particular, we have reduced the length of stay on the medical wards from 4.57 days to 4.33 days (0.24 days). Medical wards are the area where patients are most vulnerable to harm from long lengths of stay.



During the year the number of patients fit for discharge who have been delayed has fallen significantly (37.9 patients per week reduction on average for delayed transfers of care).



This success has only been possible because the whole system has worked together. Somerset County Council, Somerset Partnership Trust and Taunton and

Somerset Trust have all worked together to agree priorities, share staff and decision making and ensure pathways of care are frictionless.

A recent peer review by NHSI found good partnership working to deliver results. They commented: "*The combination of Sustainability and Transformation Programme leadership and system leadership has worked well, possibly because of the shared geography, to focus on the delayed transfer of care challenge and be determined to resolve it in the interests of patients. Realism about the current Better Care Fund funding was clear in understanding the temporary nature of it and the need to deploy it wisely to achieve the shift towards home based care was evident." (NHS Improvement (NHSI) and NHS Executive (NHSE) Peer Review, July 2017).* They recommended that we share our structure for daily Panel decision making nationally.

Robust improvement methodology has been used to implement these changes, based strongly on the SAFER Bundle promoted by NHSI (*for further information about the SAFER Bundle, please click **here**).* This has been coordinated through the Improvement Board for inpatient care. This board, chaired by the chief operating officer and the medical director, has overseen the changes, using a clear project management approach to ensure success.

Increasing demand has meant that as capacity has been released, additional patients have been able to be admitted and discharged.

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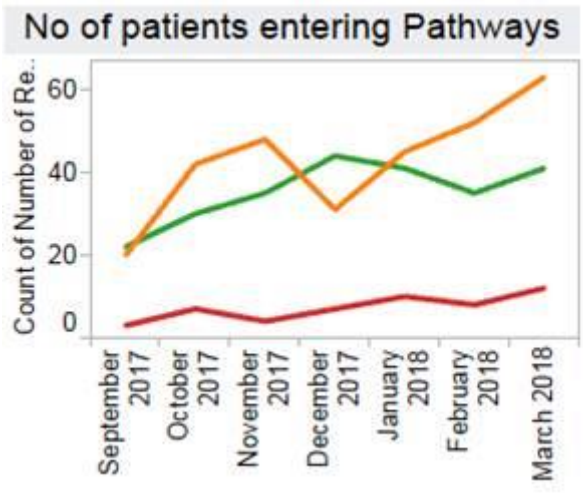
Change projects to deliver improvement in In Patient Care



Board rounds: All in-patient wards undertake daily board rounds attended by the full multidisciplinary team. Led by either the consultant or nurse coordinator, they include therapies, discharge facilitators and social care representatives. Each patient is assigned an estimated day of discharge, and outstanding barriers to discharge are identified with actions. Managerial support for these board rounds is focussed on supporting sustainable clinical team leadership.

Discharge coordination and integration: Discharge facilitators have been increased to cover 5-day working. Each ward has designated discharge facilitators, who track actions to ensure delayed transfers of care are minimised.

During 2017/18, an integrated, co-located discharge care team has been formed with clear operating standards from all team members. This includes social care, discharge facilitators, Discharge to Assess team members (Home First) and community hospital liaison nurses.

Discharge to assess

The Home First programme supports frail, vulnerable people post discharge. This test and learn programme, which has been implemented using Plan, Do, Study, Act (PDSA) steps, now covers almost all medical wards in the hospital. It provides three pathways of care - home with assessment and support (yellow on graph), community hospital enablement (green) and care home enablement (red). It has reduced waiting for enablement and, from early results, has reduced length of stay on average by five days.

The scheme also incorporates a Trusted Assessor model, with staff from both agencies being authorised to start the health and social care packages.

Decision making onward care (packages of care/ pathways/ placements): This year we have stepped up swift multidisciplinary decision making for patients to avoid delays. Daily Panels (Professional Development Forums) are held. Work has also been done to improve the quality of assessment to ensure patients are only presented once to the forum.

Criteria led discharge: For selected wards and pathways of care, nurses or therapist discharge patients against criteria. Using PDSA improvements, criteria led discharge has been refined and particularly supports discharge at weekends.

Reluctant discharge policy: A reviewed, simplified and ratified policy has been published, enabling swifter discharge in cases of dispute. Executive directors of the Trust are involved at key moments to ensure a successful outcome.

Early supported discharge: The Red Cross has worked as partners with the hospital to support patients with discharge. They ensure that the patient is settled at home with care, food and warmth, designed to reduce readmissions.

*Reducing repeated attenders***:** Musgrove Park's Emergency Department team has worked with the police, social care, mental health practitioners and the ambulance service to support patients who repeatedly attend the ED. In selected individuals, this has reduced attendances by nearly 50%.

QIP 2017/18 – Priority 5 - Improving the experience of acute services for people with mental health needs

Why is this important?

As identified in the recent National Confidential Enquiry in Patient Outcome and Death report (NCEPOD), *"Mental Health in General Hospitals: Treat as One"*, the benefits of integrating care across boundaries (e.g. health, social care, employment and housing) are understood. However, good integrated care for people with mental health conditions often appears to remain the exception rather than the rule, with physical healthcare and mental healthcare largely disconnected. This can lead to poor patient experience and reduced quality of care.

What did we want to achieve?

The Trust aimed to identify all relevant learning from the NCEPOD report and develop action plans to address any gaps it finds. It was noted that this may take several years, so the initial focus for 2017/18 was on ensuring that staff, particularly those working in high risk areas, have appropriate training, information and support to care for people with mental health conditions.

How was this measured and monitored?

The initial priority is to deliver training for staff in high risk areas, with plans in place to prioritise staff in acute admissions areas (Emergency Department and Acute Medical Unit) and six wards with the highest incidence of patients with challenging behaviours (including mental health issues, brain injury, substance misuse and dementia).

Over the year we have trained over 250 frontline staff to support an enhanced level of understanding of mental health care and how to offer support in challenging care situations. We initially targeted our very acute admission areas, where it has been well received by the staff involved. It was subsequently offered across all medical wards and some additional sessions were also put on for staff working in other areas. The plan is to continue to offer this training over 2018/19.

This work continues to be developed and monitored via an executive oversight group. This was established following receipt of the most recent annual staff survey results, to ensure a number of key actions are taken to support staff facing verbal or physical aggression from patients and relatives. Progress and impact has been reviewed by feedback from staff involved in training and it is hoped a positive impact will be seen in the 2017/18 staff survey results.

What difference did this make for patients?

Feedback from patients has generally been positive. In conversations with users about what makes their care better, the feedback has been positive about staff having an understanding of mental health issues and them taking the time to listen.

Caring for patients with mental health distress requires an enhanced skill set. The training and development that has been offered has greatly improved the staff confidence in undertaking this care. As a result of this training there have been fewer requests for specialist staff to be booked and a lower level of clinical incidence generated.

What else did we achieve and what are we doing next?

As part of the development work, links have been formed between three of the medical wards and the paediatric unit with local mental health services to support cross learning and development opportunities. This work is in its infancy but ward leaders have spent time in each other's areas and competencies and learning plans are being developed so that learning can be demonstrated and consolidated. This work is aimed at further developing the knowledge of caring for patients with mental health needs in the acute Trust.

A closer working relationship with the mental health service is bringing many enhanced opportunities for learning and improving care. This will be continued over the coming year.

QIP 2017/18 – Priority 6 - End of life care

Why is this important?

End of life care remains a core part of the Trust's responsibility to the community. Musgrove will often identify the life limiting illness or be the place of admission in the context of acute admission on a background of increasing frailty as well as caring for more than 1,200 people who die in the hospital each year. It is uniquely placed to initiate and coordinate the individual's care in the latter stage of their life in the context of what is important for the individual.

What have we achieved?

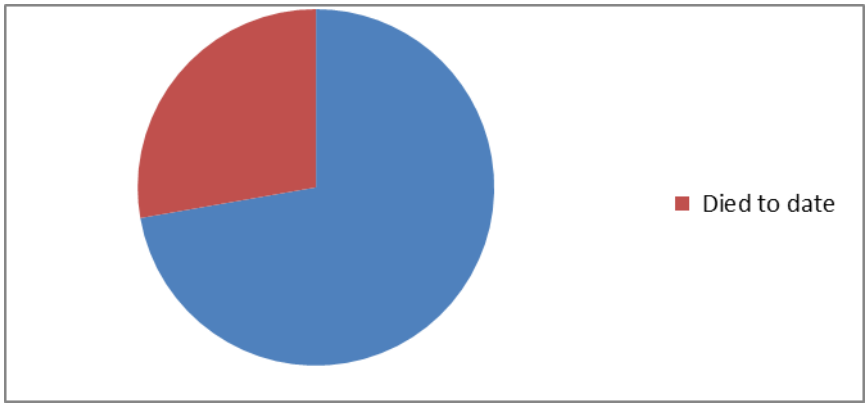
We have continued to build the culture that good end of life care is fundamental to what we do. Examples of how we are achieving this include the inclusion of end of life metrics in the Trust's Quality Assurance Framework and Art for Life's support in our Dying Matter's week "Big Conversation".

The Care Quality Commission raised their overall rating from ‘requires improvement’ to ‘good’. This was positive but left much work to do in pursuit of an outstanding rating.

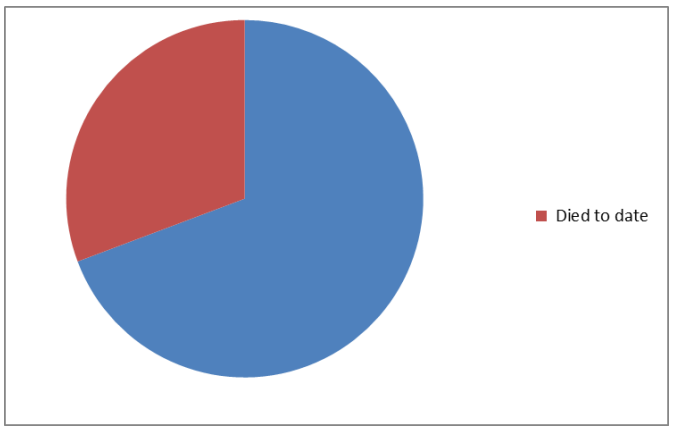
The life limiting illness/end of life discharge summary is now part of the Electronic Patient-Reported Outcome (EPRO) system. This tool, has allowed the Quality Improvement Nurse Practitioner to work with medical staff to improve the quality of information shared with primary care.

The project has built on our relationship with Marie Curie. It has allowed a much clearer understanding of when and how to undertake advance care planning in the context of those factors which are important to the patients and their families. We have learnt that often by the time an older person has had an acute admission to hospital they have less energy to express what is important to them. Nonetheless by identifying those who we think are likely to die in the next year, even if it is not possible to complete an advance care plan, a change in outcome against what would traditionally be expected has been observed.

Since starting 151 patients have been seen of whom 58 have subsequently died:

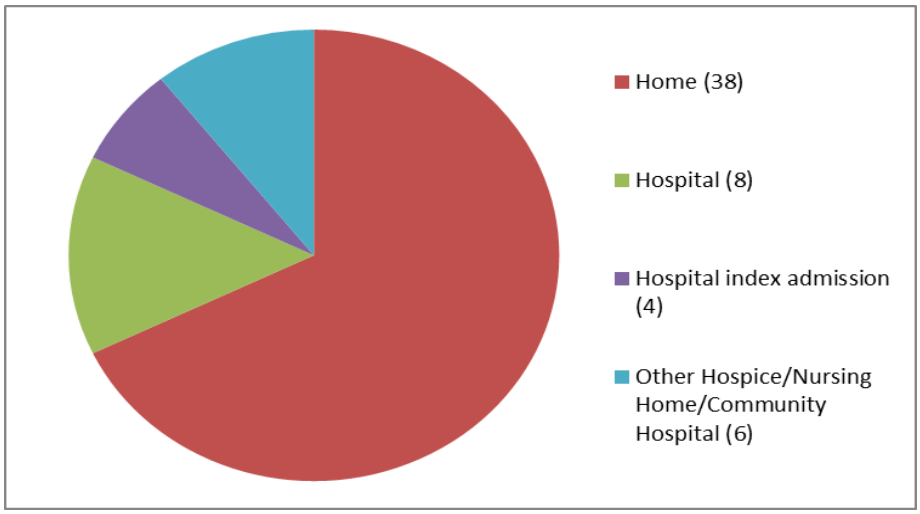


The expected numbers based on nationally published area specific data for Somerset are for 46% of people to die at home or in a care home.



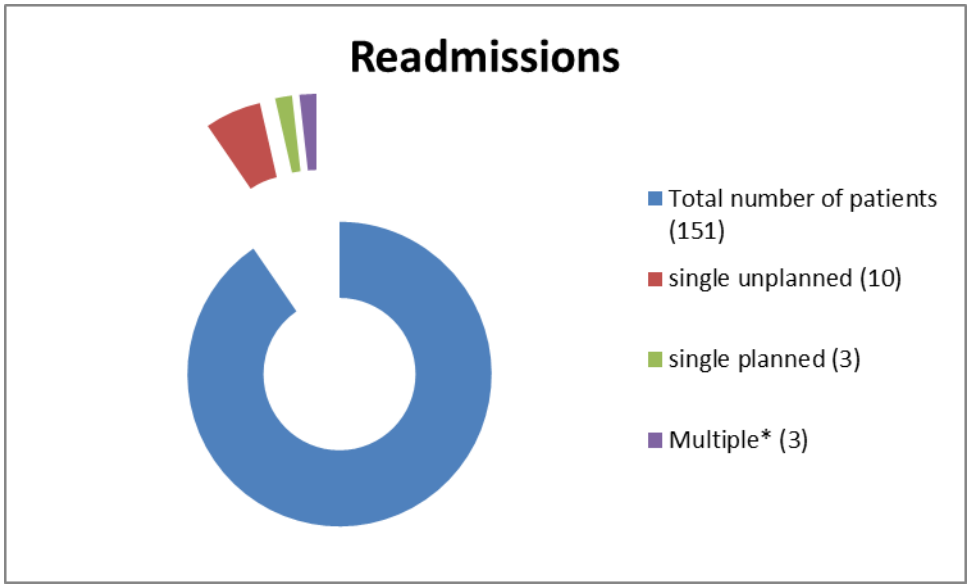
Of those who were seen as part of this pilot and subsequently died, 67% died at home and 9% died in a care home (4), hospice (1) or community hospital. Of the 24% who died in hospital, four of eleven patients, died on the index admission before a meaningful advance care process could take place.

Place of Death of those seen:



It is recognised that patients in their last year of life use healthcare systems more frequently. They would be expected to be admitted on average three to four times.

Within the pilot cohort there have been five single unplanned and entirely appropriate admissions (urosepsis), three planned admissions (e.g. ureteric stent placement for symptom control) and three patients who have had multiple admissions - a total of 10 between them. This is a total of 23 admissions in 151 patients.

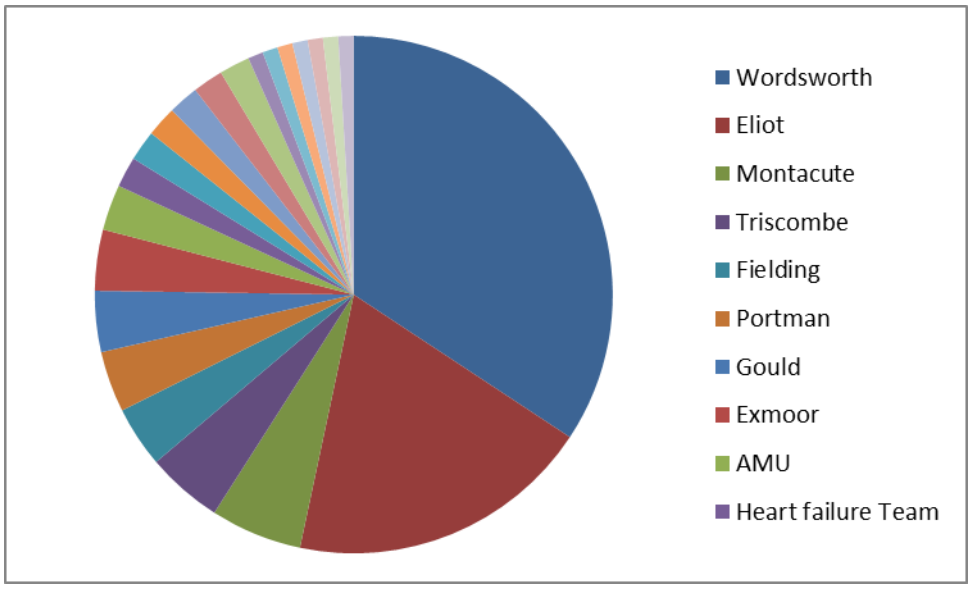


These data suggest that this process of initiating a conversation with a family and communicating it effectively to primary care can change the subsequent pattern of care use.

In 2018/19 the challenges will be to consolidate the work of the pilot where two wards contributed the majority of patients throughout the hospital and to create

meaningful expectation around life limiting illness discharge numbers for different directorates.

Wards patients were referred from:



How this will be measured and monitored?

We are looking to formalise the measurement of the life limiting illness discharge summary as part of the Quality Assurance Framework (QAF). The discharge summary was formally ratified by the Trust's IT governance procedures in December 2017. We are working with Informatics to incorporate these data into the QAF.

In 2018/19 we plan to measure days spent out of the hospital by people in their last year of life. We believe this will give a better measure of person-centred care.

How has this information been reported?

The data presented on this report has been shared with the Charitable Funds Committee who have sponsored the specialist nurse from her appointment. The outcomes have been shared with the Inpatient Improvement Board, who have supported the project.

We are currently working with the Informatics team to create a report for the directorate QAF with regards use of the life limiting discharge summary. This will be added to the other end of life metrics; namely, use of the Treatment Escalation Plan and the use of the individualised End of Life Plan. This will allow a broader view of an individual's care in the latter stage of their life.

Future challenges and opportunities

There is the opportunity to use Marie Curie trained volunteers to support advance care planning in the community. This would allow earlier planning and provide a person- centred care priority which could inform medical advance care plans, treatment escalation plans, special notices and the electronic palliative care coordination system. The Somerset Integrated Digital Electronic Record offers the promise of linking common data points. End of life care is ideally placed to be an early area for development.

The palliative care team has seen changes in consultant and nursing members, neither of which are back up to full staffing numbers. This is challenging when the establishment has been previously recognised as being small in relation to other organisations of a similar size. There is an opportunity to collaborate with Yeovil District Hospital NHS Foundation Trust to add new funding to a 0.6 whole time equivalent vacancy to create an enhanced supportive care service for lung cancer. These services have been shown to improve the experience of the illness, which has enhanced the quality and prolonged the length of life.

In 2018/19, a Somerset Treatment Escalation Plan (STEP) will be introduced. It is envisaged that as with the Treatment Escalation Plan, introduced in the hospital in 2014, this will be a lever that catalyses a positive improvement in end of life care across the community.

The spiritual care team are essential to holistic care of the most vulnerable in the hospital. They have also seen change in staffing and remain in need of further volunteer and Trust supported team members. They have a newly appointed lead who is working to produce a policy for spiritual care. How this team can grow and thrive to support those dying and those around them is a key challenge.

The bereavement service is another important facet of care for relatives. A new lead nurse has recently been appointed to the team. A handover period will make it possible to maintain the excellent work which will link with mortality and quality review processes to enable learning from good practice, alongside any improvements which could be made.

QIP 2017/18 – Priority 7 - Improving patient experience for inpatient and outpatient care, linked to the priorities for the Trust's improvement work

What have we achieved in the last 12 months?

The roles and responsibilities of the improvement team are now established and seven boards are in place:

i) *Theatres*: Enhanced recovery has successfully been rolled out to Hestercombe ward. SCORE is a safety culture survey which was completed by theatres, the pre-operative assessment clinic and surgical staff in March 2017. Results regarding the learning environment, local leadership, burnout climate, personal burnout, team work, safety climate and work life balance are being fed back to teams to help identify areas of good practice and where improvements can be made. There will be a focus on change ideas in January 2018.

ii) *Inpatients:* The Emergency Department has continued to improve. The number and skill mix of staff has increased with GPs and physios seeing patients in the department. Half the department has undergone a complete rebuild, offering better consultation rooms, increasing patient confidentiality and improving the rooms for the care of children and those in mental health crisis. Concentrated work on discharge planning has resulted in inpatients being discharged home sooner. This has included work on improving the reach of rehabilitation for patients in their own home and in community hospitals and specific care homes. Joint working between health and social care teams has improved decision making and streamlining discharge processes to increase efficiency. Piloting of the national Red Bag scheme was initiated this year. This scheme aims to reduce delays for patients admitted from care homes by ensuring availability of key information that is critical to delivering timely care and good patient experience. In addition, the Trust has joined a national collaboration to test real-time feedback across six areas to understand if this methodology supports improvement in patient experience.

iii) *Outpatients:* Introduction of self-service kiosks to outpatient areas to support patients booking themselves into appointments and ensuring they are signposted to the right place. New room scheduling system is being introduced to improve the efficiency of clinic booking. The Advice and Guidance service has been enhanced and spread to new specialties. The Trust has reviewed and extended the use of third party printing to reduce costs and improve the quality of patient correspondence.

iv) *Collaborative Patient Care:* Discharge summaries are being reviewed. Home First has had a focus on discharge from hospital, and a cross-organisational group has worked together to pilot this scheme. In its first four months it has supported over 300 people. A programme of work is being prioritised for 2018 and will include a series of projects with primary care, Somerset Partnership NHS Foundation Trust and social care.

v) *Patient Safety:* This board has been established in January 2018 and its first project will be to support the ambitions for sepsis screening and action.

vi) *Colleague Development:* The board has now prioritised five projects – recruitment, apprentices, retention, temporary staffing and prevention agenda. The prevention agenda has worked to introduce the national programme 'Make Every Contact Count (MECC)'. This is about recognising the opportunity to encourage change in people by talking about their health and wellbeing in every day interactions. Making Every Contact Count seeks to improve the individual, community and the population's health and wellbeing. There is a further project focused on improving the recruitment process.

vii) *Digital programme:* The digital team is working towards the implementation of a digital system in critical care in July 2018. Since IMS MAXIMS went live in September 2015, varying types of change requests have been logged and while there are plans in place to digitalise the Trust, an emphasis needs to be given to review and optimise MAXIMS in theatres. In January there will be observational activities to follow the patient journey through theatre. Day Surgery is due to go live with the inventory system in January 2018 and currently 82% of Day Surgery staff has been trained in the use of the system.

Patient and family-centred care

As part of our commitment to improving patient experience, Taunton and Somerset NHS Foundation Trust has committed to becoming an exemplar for the Patient and Family Centred Care (PFCC) approach. PFCC advocates that we enable patients and their defined family to be partners in their own care and decision-making at a clinical level and at an organisational level in designing, developing and evaluating services. Over the last 12 months we have achieved the following:

- The role description and framework for the Musgrove Partners (patient voice volunteers) has been re-designed collaboratively. This has facilitated the Musgrove Partners to be the patient voice within multiple improvement projects and as part of regular activities such as recruitment of staff.

- Together we have co-designed the tool that will measure our baseline position as a patient and family centred Trust. The testing phase is complete. We are currently working together to evaluate the test of the tool and move into the implementation phase.

- The test phase has allowed for conversations between Musgrove Partners and select staff about the elements that make an organisation patient and family centred. It has allowed staff to celebrate the excellent care approaches in their area and stimulated ideas about what further steps could be taken to further develop this approach. This will also allow for learning from each other as the project develops.

- Activities to inspire staff about engagement with patient partners for improvement of services, and how to best hear the patient voice about experiences of our services have been completed over the year. Raising awareness about the Trust's ambition for patient and family centred care has furthered the conversations about what we already do well, and areas where we have progress to make. In the coming year as the baseline is completed we will prioritise projects supporting the patient and family centred approach.

QUALITY IMPROVEMENT PRIORITIES 2018/19

The Trust has continued to develop the system for agreeing the quality priorities. Based on the wide ranging evidence already available in the Trust about patient safety and care, and on our progress with last year's CQUIN targets, several quality topics were identified as having room for improvement or focus. These topics were developed in consultation with the Trust's Governor Patient Care Group.

The priorities for this year are firmly aligned to the Somerset STP and are shared priorities with Yeovil District Hospital NHS Foundation Trust. Progress on achievement of the quality priorities will be overseen by the Trust's Governance and Quality Committee via reports from the Governance Support Unit, at least quarterly. In addition, individual priorities will be monitored via a number of groups and committees in the Trust, as detailed in each of the sections below.

In March 2018, the Trust's Council of Governors agreed the following key quality improvement priorities for 2018/19, building on performance in 2017/18, as reported above:

Priority 1: Learning from deaths

Embed processes where investigation and learning occurs if care concerns have been identified and may have led to the outcome for the patient (measured by HSMR, SHMI, Serious incidents, Mortality reviews).

Priority 2: Safer care

Continuous reduction in avoidable harm – (measured by incidence of infections, pressure ulcers, falls, medication incidents, maternity safety metrics, implementation National Early Warning Score 2 and Streams, compliance with sepsis CQUIN (Commissioning for Quality and Innovation), serious incidents and never events).

Priority 3: Mental health and holistic care

Increase staff capability to recognise and respond to those with mental health needs (children, adults in crisis and older people). This will be measured by training compliance in conflict resolution, eating disorders, adolescent mental health e-learning, number of mental health first aiders, establishment of psychiatric liaison pathways.

Priority 4: Patient experience

Improve patient experience using co-design, personalised care planning and family centred care to inform service improvements and care pathways (measured by complaints, PALS concerns, public engagement events and user engagement in identified work streams).

Priority 5: Right care, right time, right place

Strengthen collaborative working across the health and social care system to deliver sustainable improvements in care, and in line with the Somerset Clinical Strategy, (measured by involvement and progress with seven day services compliance, end of life care measures, improving discharge, Health and Care Strategy work streams and improvement programmes).

Priority 6 Staff retention and wellbeing

Develop a robust approach to staff retention across all staff groups with a focus on celebrating excellence in practice, promotion of wellbeing support and activities, opportunities for development and career progression within Somerset and across providers (measured by recruitment and retention numbers, staff survey results, delivery of strategies and workplans).

QIP 2018/19 - Priority 1 - Learning from deaths

Why is this important?

The review of mortality information is important to help improve care and ensure patient safety within Musgrove Park Hospital. Mortality data from both qualitative review (at directorate/departmental level) as well as higher level quantitative data needs to be used to aid 'learning from mortality' within the Trust, as well as provide oversight and governance around inpatient deaths. Mortality review and specifically 'learning from deaths' cannot be taken in isolation and is intricately linked to the Trust review of serious incidents via the Serious Incident Review Group (SIRG) and departmental/directorate governance.

What do we want to achieve?

The mortality surveillance group aim to achieve:

- Deaths within priority patient criteria are identified and included for both standard and group-specific review.
- Mortality reviews are completed using the Trust proforma and with clear judgement on quality and avoidability.
- Specialty mortality and morbidity meetings are held and discussion of outputs and learning documented.
- Cases with significant concerns are referred for investigation via the serious incident review process.
- Established directorate and topic-based review to identify learning.

Examples of action taken

Specific examples of action taken include, teaching on end of life care within general surgery/vascular patients and the involvement of the learning disabilities team within respiratory medicine. These can be cases that are identified through the mortality process and are referred through to the serious incident review group.

Performance to-date

During April 2017 March 2018, 1,352 patients died in Taunton and Somerset NHS Foundation Trust.

By 6 April 2018, 595 case record reviews and three investigation has been carried out in relation to 532 of the deaths.

19 (3.6%) of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

How this will be measured and monitored?

The Mortality Surveillance Group (MSG) is formed to support the Trust in delivering its obligations to monitor patient outcomes and ensure clinically effective care. It's objectives include to develop and oversee the systems relied upon to review deaths within the hospital, including specialty mortality and morbidity meetings and to ensure an effective response to signals of quality concerns within the relevant sources of intelligence about outcomes.

MSG's responsibilities include to review the benchmarked standardised mortality rates of the Trust and specialty-based mortality and morbidity activity with a view to identify potential areas for investigation and gain assurance on the operation of effective review processes at service level. This will be achieved via structured

reporting to address specialty level mortality and morbidity resources, structures, process and outputs.

Duties also include consideration of the mortality data in conjunction with other qualitative clinical data and to identify areas for investigation, ie. to consider the outputs of local case note review, mortality and morbidity activity alongside statistical (Standardised Mortality Rate Ratio) data and other contextual information about the service and the data and to investigate alerts and other outlier notifications received from the Care Quality Commission or identified systems (e.g. HED, national databases, national audits).

The mortality review policy is monitored at the MSG via the monthly mortality review report.

MSG reports key metrics to the board on a quarterly basis.

QIP 2018/19 - Priority 2 - Safer care

Sepsis- compliance with CQUIN (Commission for Quality and Innovation)

Why is this important?

Sepsis claims more lives than lung cancer, the second biggest cause of death after cardiovascular disease, and is the cause of more than double the annual deaths from breast and bowel cancer combined. There is on average a 10% risk of mortality associated with sepsis which rises to 40% in the case of septic shock.

What do we want to achieve?

- 90% of patients who need to be screened for sepsis are screened;
- 90% of patients who have been screened and require antibiotics receive them within one hour;
- 90% of patients who have antibiotics are reviewed at three days.

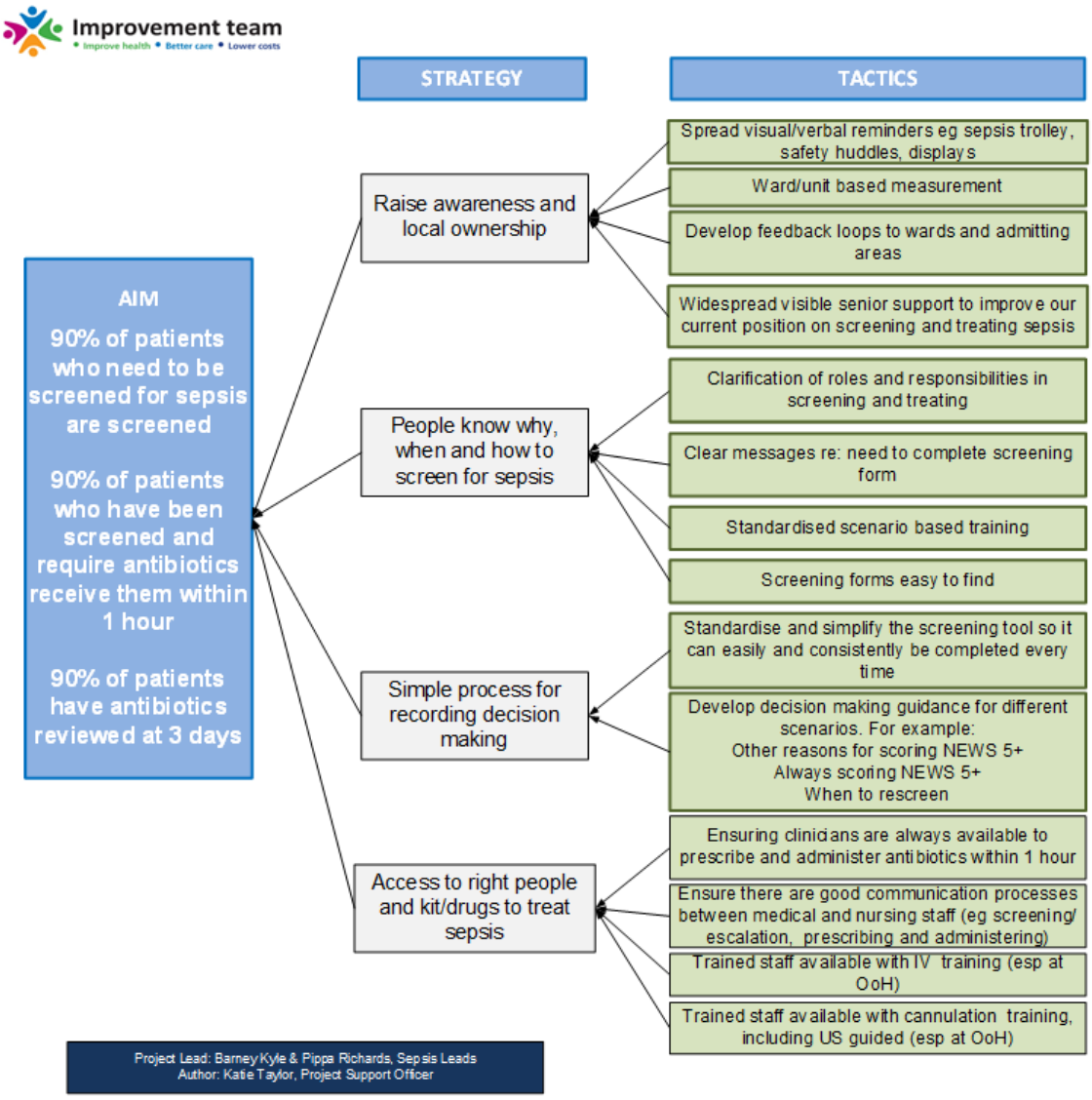
Examples of action taken

These include initiating ward level audits of performance in order to direct feedback on a local level, using the Outreach Team to ensure that a screening form is done for all referrals, placing prompting posters on all notes trolleys and implementing a communication strategy. This involved the sepsis lead presenting recent data to clinical directors asking for improved engagement, including updates in Trust bulletins for staff awareness and expanding the sepsis steering

group membership to include members of the senior nursing team. This is to provide further support and to challenge inpatient wards to meet the required standard.

More recently, a Trust-wide survey (completed by more than 150 staff) together with face to face interviews and feedback from sepsis champions, has given the Trust a more in depth understanding of why screening and delivering antibiotics within one hour is not always achieved. Small teams around the Trust are due to start implementing change ideas, supported by the sepsis leads and improvement team. The driver diagram below shows the key strategy and tactics for improvement.

Key Strategy and Tactics for Improvement

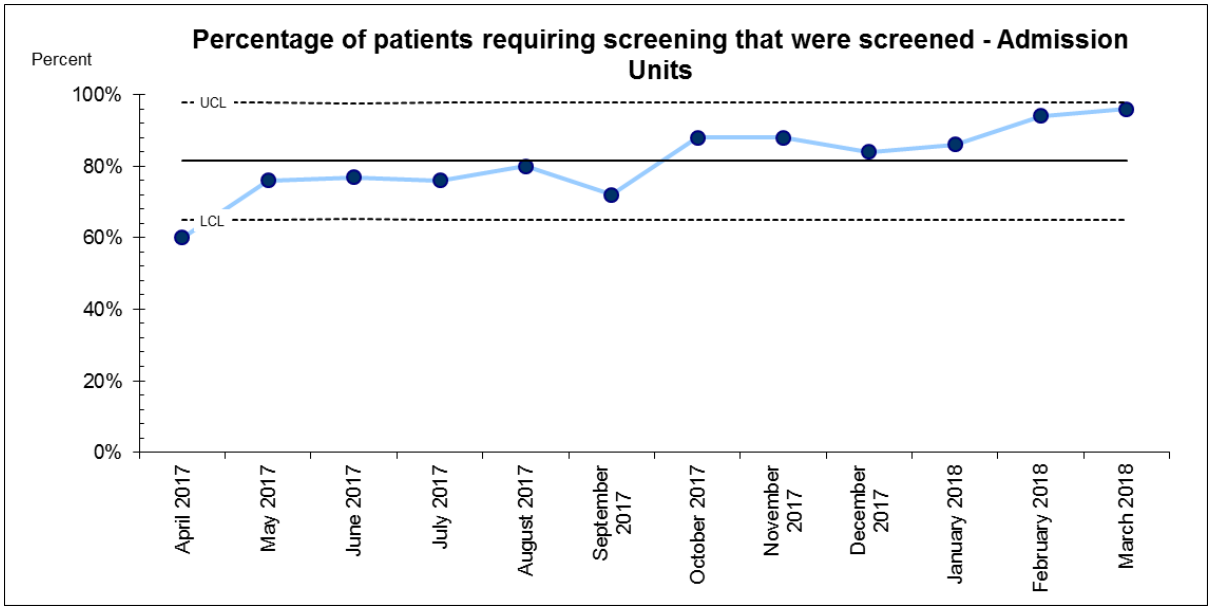


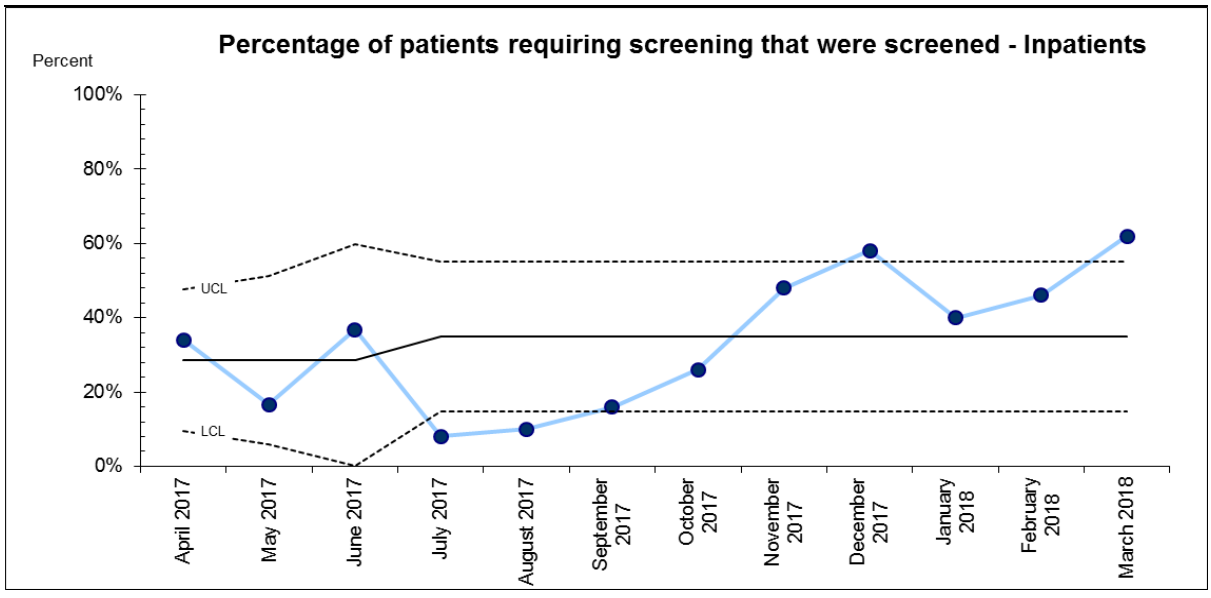
Performance to-date

The recent results demonstrate improvement in sepsis screening for both admission units and inpatients:

- The Q4 admission unit screening rate is 92.0% (vs 86.7% in Q3, 76.0% in Q2 and 71.1% in Q1).
- The Q4 inpatient screening rate is 49.3% (vs 44.0% in Q3, 11.3% in Q2 and 28.6% in Q1).

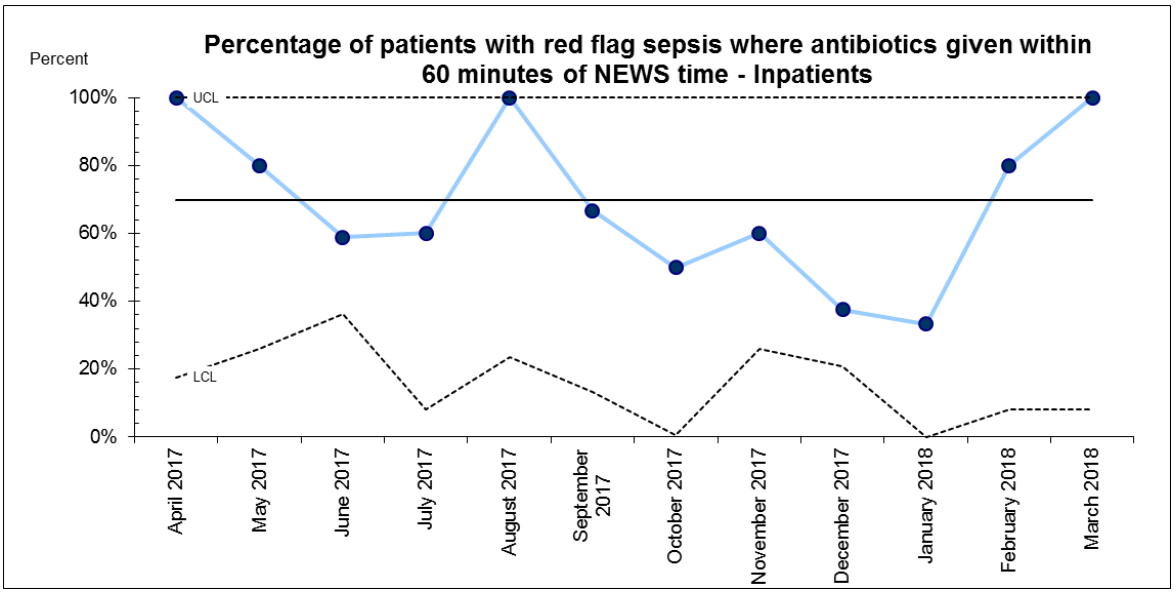
As part of the National CQUIN the Trust audits cases to see whether they have been screened for sepsis, given timely antibiotics and that the prescription for antibiotics were reviewed. The Trust is aiming to achieve 90% and above. The results of the CQUIN indicators are as follows (higher is better).

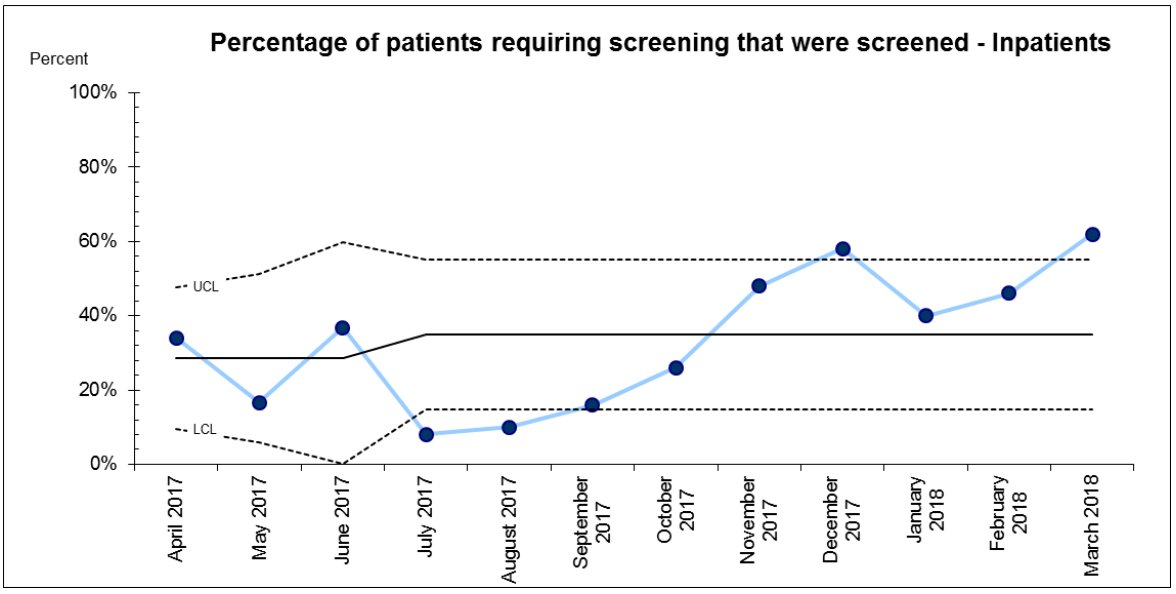




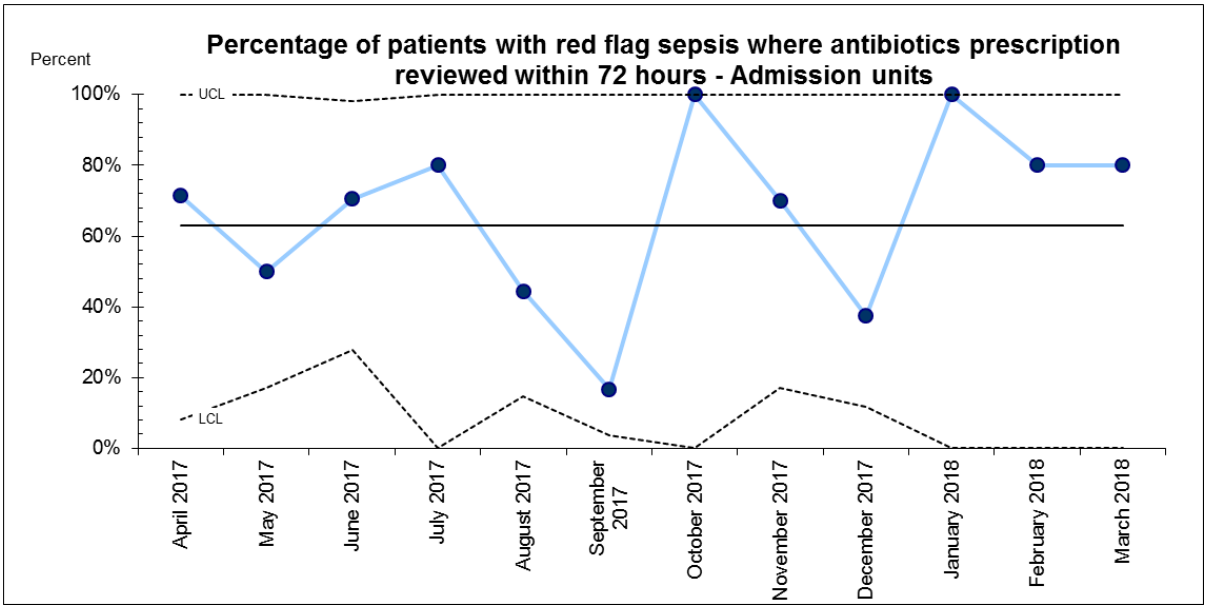
The rates for timely antibiotics are variable which is partly due to the small numbers of red flag sepsis patients identified in the audit. The percentage of patients treated with antibiotics within an hour is less compared to previous quarters but is still higher than the minimum requirement of 50%.

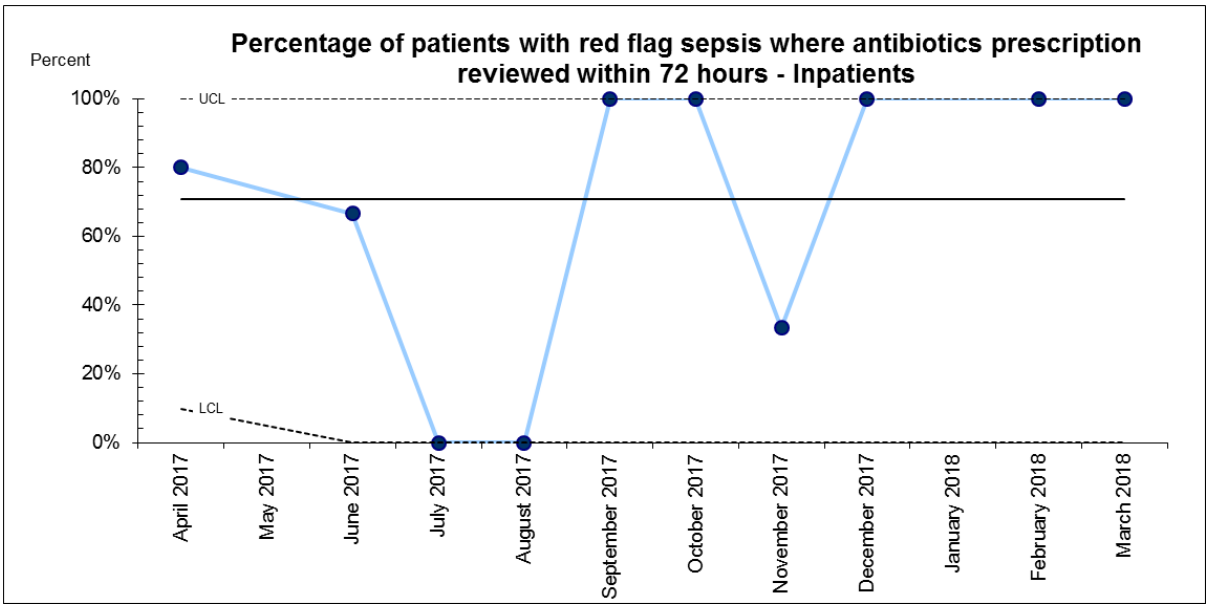
- The Q4 admission unit timely antibiotic rate is 76.9% (vs 50.0% in Q3, 80.0% in Q2 and 73.5% in Q1).
- The Q4 inpatient timely antibiotic rate is 66.7% (vs 62.5% in Q3, 60.0% in Q2 and 87.5% in Q1).





- The Q4 admission unit antibiotic review rate is 84.6% (vs 63.6% in Q3, 45.0% in Q2 and 64.7% in Q1).
- The Q4 inpatient antibiotic review rate is 100.0% (vs 75.0% in Q3, 40.0% in Q2 and 75.0% in Q1).





How this will be measured and monitored?

The sample for the admission units includes patients triaged with a National Early Warning Score (NEWS) of three or more in the Emergency Department (five or more from January 2018). The sample for inpatients includes patients on the outreach register with NEWS of five or more.

The case note review is conducted by a registered nurse within the Governance Support Unit and practice is assessed in accordance with the CQUIN requirements. The results are monitored by the Sepsis steering group and the Quality Assurance Committee. The Patient Safety Improvement Board has oversight of the sepsis steering group.

Sepsis CQUIN data is also reported and monitored as part of the Performance Assurance Framework.

Maternity Safety Metrics

Saving babies lives care bundle

Why is this important?

The Saving Babies' Lives Care Bundle brings together four key elements of care based on best available evidence and practice in order to help reduce stillbirth rates.

What do we want to achieve?

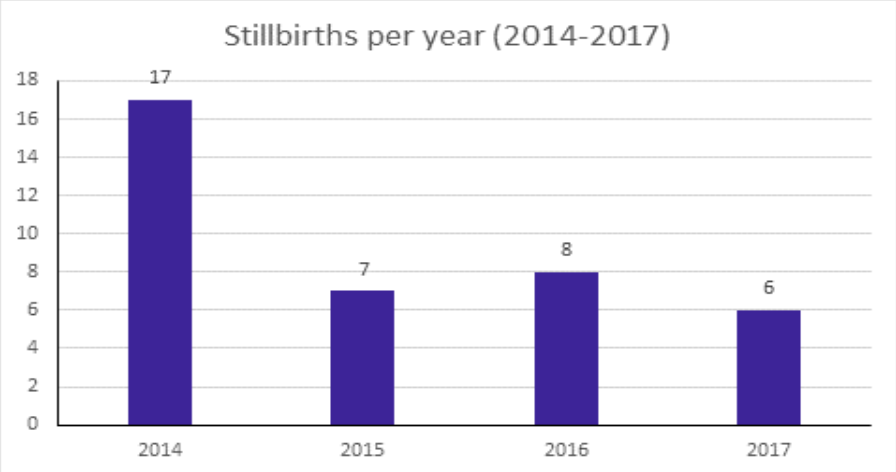
By using the care bundle we want to continue to reduce and sustain our number of stillbirths.

Examples of action taken

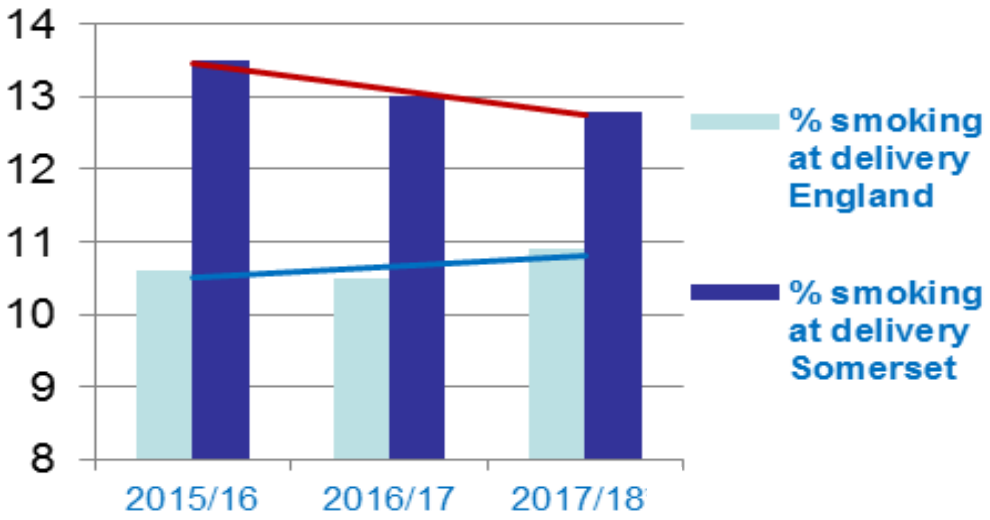
1. Reducing smoking in pregnancy – 85% reduction in SATOD (Smoking Status at Time of Delivery) – Carbon monoxide monitoring at booking and referral to smoking team.
2. Risk assessment and surveillance for fetal growth restriction – introduction of GAP and GROW and the use of customised growth charts and serial growth scans.
3. Raising awareness of reduced fetal movement – fetal movement leaflets given out and discussed at every antenatal appointment.
4. Effective fetal monitoring during labour – all staff working on labour ward is competent to interpret CTG. K2 package for all trained staff.

Performance to-date

Since the care bundle was introduced in 2015 are target of > 50% reduction has been achieved and sustained.



In 2017 we reached 1000 babies born smoke-free supported by our Specialist Smoking Cessation Midwife team.



How this will be measured and monitored?

This will be monitored through a patient notes audit.

Sepsis

Why is this important?

In many cases, delayed recognition of sepsis enables the unrestrained progression to septic shock and multi-system organ failure. Once this happens there is little hope of successful treatment, with mortality rates rising as high as 60%. Rapid recognition and treatment of sepsis is essential to reduce preventable deaths.

What do we want to achieve?

A sustained improvement in sepsis management – with blood cultures and antibiotic management given within the first hour.

Examples of action taken

Implementation of the maternity Sepsis action tool.

Sepsis champions who attend the trusts study days and then give feedback to the teams – they also audit notes and distribute sepsis stars to all staff that use the screening tool and give the antibiotics within the golden hour.

Performance to-date

Our 2017 aim of 90% of women with suspected sepsis receiving Sepsis Six intervention within the ‘golden hour’ was achieved. In the fourth quarter of

2017/18, 91.8% (n=49) of women who triggered for sepsis had a screening proforma started.

70% of patients identified as having red flag sepsis and needed antibiotics received them within one hour of trigger time.

How this will be measured and monitored?

This will be monitored through a patient notes audit. All patients who don't receive antibiotics within the hour will be reviewed.

Perinatal Mental Health

Why is this important?

Perinatal mental health refers to a woman's mental health during pregnancy and the first year after birth. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period.

What do we want to achieve?

To provide a service so that the mental health of all women is monitored, discussed and treated in the same way as her physical health during this crucial time.

Examples of action taken and performance to-date

Our specialist multidisciplinary perinatal mental health team was launched in October 2016. Since then 242 women have been supported by the team.

How this will be measured and monitored?

This will be monitored through audit.

Incidence of infections

Why is this important?

A reduction in the incidence of hospital acquired infection will improve health outcomes for patients, provide better care and have a financial impact for the Trust through a reduction in length of stay and potential complaints.

Noroviruses are a group of viruses which are the most common cause of infective gastroenteritis in the UK. They are highly infectious and cause regular outbreaks of diarrhoea in the community and hospitals. Norovirus outbreaks can occur at any time of the year, but are more common in the winter months with hospital outbreaks often leading to ward closure and major disruption in hospital activity.

Methicillin resistant staphylococcus aureus (MRSA) is an organism which is resistant to the antibiotics usually used to treat infections caused by the staphylococcus aureus bacterium. Infections caused by the bacterium can range from mild to life threatening and can be particularly hard to treat as special antibiotics have to be used.

Clostridium *difficile* (CDI) is a bacterium that is present in the gut of up to 3% of healthy adults and does not normally cause any harm. CDI can occur when the normal bacteria in the gut are disturbed, usually by taking antibiotics. This allows the bacterium to multiply rapidly in the gut and produce toxins which cause diarrhoea, and in some cases severe inflammation of the bowel.

What do we want to achieve?

We want to achieve the handwashing local target of 90% compliance.

Regarding MRSA, the Trust's aim for 2017/18 was to have no MRSA Trust-apportioned bloodstream infections (specimen taken on or after the third day of admission, in line with the standard national definition) as agreed with the Trust's commissioners**.**

Examples of action taken

Hand washing

A key component in the reduction of infection is thorough hand hygiene by all clinical staff. This is an important issue for the Trust and all our patients.

Monthly hand hygiene compliance audits are carried out in all areas. The Infection Prevention and Control team also undertakes hand hygiene validation audits to check the reliability of the data collected and identify areas for improvement. Results are fed back to directorate managers, senior nurses and the ward sisters and teams.

Environmental cleaning

A high standard of environmental cleaning is a key infection control measure for CDI and MRSA. A new centrally managed cleaning arrangement was introduced in the Trust in November 2017, which will help ensure a high standard of cleaning in all areas of the hospital and ensure that any gaps in the cleaning service are readily covered in high risk areas.

Clostridium difficile Infection (CDI)

The Trust continues to implement a number of actions to help reduce the risk to patients, which includes:

- Robust antibiotic stewardship to help reduce the unnecessary use of antibiotics;
- Prompt Isolation of patients with diarrhoea and / or a confirmed CDI;
- Isolation of patients with a history CDI, if they are at an increased risk of developing symptoms;
- Scrupulous hand washing with soap and water following contact with patients with CDI;
- Regular review of patients with CDI by a microbiologist and the Infection Prevention and Control team, to support medical management and isolation practice;
- Enhanced cleaning of rooms with hydrogen peroxide based technology to help eradicate CDI spores;
- Enhanced cleaning of equipment with a sporicidal agent;
- Working closely with the Trust's partners in the community to help reduce the risk of CDI in primary care.

Norovirus

Outbreaks were managed in line with the Trust's 'Management of Norovirus' policy and the *Guidelines for the management of norovirus outbreaks in acute and community and social care settings' (DH Norovirus Working Party December 2011).*

Performance to-date

Hand washing

Local Target: 90% compliance

Actual 2017/18 – 94%

Norovirus

In 2017/18 there were 23 confirmed norovirus outbreaks in the Trust, resulting in restrictions being put in place on wards.

MRSA

Unfortunately, the Trust had three cases of MRSA bloodstream infections in 2017/18. Multi-disciplinary reviews were completed to identify the source of the infection and any areas of sub-optimal practice that may have contributed to the case. Opportunities to improve a) MRSA screening and b) checking patient histories for any previous history of MRSA were identified and this learning was shared and improvement actions put in place.

Clostridium difficile Infection (CDI)

In 2017/18, the Trust had a total of 18 Trust-attributed cases (defined as specimen with a positive toxin test result taken on or after the fourth day of admission). This was a sharp increase from the previous year when there were only eight cases identified. However, there has been a general increase in CDI across Somerset this year compared to last year, and this may have had an impact on the number of hospital cases.

All cases of Trust-apportioned CDI are thoroughly investigated to assess whether the case was linked to any lapse in care, and therefore potentially avoidable. These assessments are subsequently peer reviewed and validated with the Trust's commissioners. In five of the 18 cases a lapse of care that could have contributed towards the case was identified. Learning included ensuring appropriate antimicrobial prescribing and compliance with hand hygiene, and this was shared with the appropriate clinical staff and improvement actions taken. In the remaining 13 cases no lapses of care that could have contributed to the case was identified.

A high standard of environmental cleaning is a key infection control measure for CDI. A new centrally managed cleaning arrangement was introduced in the Trust in November 2017, which will help ensure a high standard of cleaning in all areas of the hospital and ensure that any gaps in the cleaning service are readily covered in high risk areas.

To ensure the optimal use of antibiotics, antimicrobial stewardship remains a high priority in the Trust, with regular review of broad spectrum antimicrobial prescribing on both medical and surgical wards by a consultant microbiologist and antimicrobial pharmacist.

The use of high risk broad-spectrum antibiotic prescribing has significantly reduced in favour of lower risk combination therapy with narrow spectrums agents, and the Trust remains amongst the lowest users of these agents in the region.

How this will be measured and monitored?

Handwashing

- Monthly hand hygiene compliance audits
- Monthly environmental audits
- Monthly antimicrobial stewardship audits.

MRSA, CDI and Norovirus

- All Trust-apportioned cases are investigated to identify learning. Learning is then shared within the organisation in order to drive further improvements.

Falls

Why is this important?

For the hospital

- Financial impact – additional bed days
- Clinical Quality Commission / Health Service Executive interest / follow up
- Potential for prosecution or fines and associated costs
- Reputation of the hospital.

For the patient

- Poor outcome - Fracture neck of femur, which is associated with a 30% mortality within one year
- Increased length of hospital stay
- Patient may not be able to go back to own home
- Loss of confidence
- Decreased mobility
- Reliance on family or friends.

What do we want to achieve

Reviewing all the falls and the Royal College of Physicians data indicated, two distinct issues were identified where improvements need to be made:

- Getting it right at the front door: On admission acutely unwell confused patients in a new environment, or moving rapidly between environments, need actions in place to keep them safe.

- Discharge: Patients are at particular risk when they are medically fit but are unable to be discharged due to functional or social issues. Prolonged hospital stays are associated with deconditioning. People over 80 have a 50% chance of falling at home if they furniture hop. The Trust is working with the enablement lead and the Home First teams to coordinate the best approach for these patients.

Examples of action taken

- Following a spike in falls with significant harm in 2015 the Falls group refocussed its attention on this area. The refocus gained senior management leadership and Sign up to Safety involvement.
- The Trust has a well-functioning group with good multidisciplinary representation and engagement.
- There is good assurance that policies and procedures are in place.
- We are working on a change culture so that every fall matters.

How?

- Building relationships with key staff who deliver care on the wards;
- Ensuring all staff understand the implications to patients confidence and wellbeing even if no serious physical harm has occurred;
- Working with Somerset Partnership NHS Foundation Trust and other agencies towards a Somerset Pathway;
- Change in paperwork to meet the new Royal College of Physicians and NICE Guidelines;
- Royal College of Physicians audit;
- Robust data for all falls identifying trends and feedback to the wards;
- There is a specific piece of work on the Acute Medical Unit being carried out with the improvement team.
- From work undertaken on Wordsworth ward the Trust has learned that a significant difference is made when the senior leadership ward team are passionate and engaged about preventing falls and the senior nursing lead is engaged and supportive.

Performance to-date

Between April 2017 and March 2018, there were 1,147 falls incidents reported (4.96 per 1,000 bed days and day cases) compared to 1,019 (4.46 per 1,000 bed days and day cases) in 2016/17.

Of these, 22 incidents were scored as moderate or worse between April 2017 and March 2018 whereas 30 were scored moderate or worse in 2016/17.

How this will be measured and monitored?

The Falls group receives and reviews incident data for all falls for learning and recommendations for change.

It also reviews regulatory and national data.

Streams

Taunton and Somerset NHS Trust are collaboratively working with DeepMind health to develop their Streams application which will enable us to achieve our Global Digital Exemplar Milestone of the Management of the Deteriorating Patient; this will be completed over a phased approach of development and user design workshops.

In its current state of development the Streams application can be accessed via a mobile device which allows multiple clinical staff to view a patient's observation capture and National Early Warning Score at any one time and within any location within the Trust. This gives clinical context in relation to observations to any referral/handover of care received within the Trust to support decision making and

oversight of the unwell patient. The app will drive clear and accurate observation capture and the correct calculation of a NEWS score, providing the Trust with guidance with regards to the appropriate escalation route for patients.

How this will be measured and monitored?

A pilot is planned on Montacute ward with a plan to remove the current paper process and roll-out the app across adult wards within the Trust. Baseline measures are being captured which include:

- Timeliness of observation rounds
- Timeliness of finding clinical documentation
- Legibility of observation capture
- Observations captured according to Trust policy
- Correct calculation of National Early Warning Score.

Data will then be captured to measure the performance and benefits provided by capturing digital observations within Streams.

Pressure Ulcers

Why is this important?

A reduction in the incidence of hospital acquired pressure ulcers will improve health outcomes for patients, provide better care and have a financial impact for the Trust through a reduction in length of stay and potential complaints.

Examples of action taken

The management of patients at risk of pressure ulcers has been one of the key patient safety priorities at the Trust for a number of years. It is a key component of the South West Patient Safety and Improvement Programme, Patient Safety First campaign, Safer Patient Network, Safer Patient Initiative and the Trust's own Improvement Network. As a result of involvement in these collaborates the Pressure Ulcer Steering Group has developed a strong background of improvement science and measurement for improvement.

Over the last five years the Trust has seen significant reductions in the number of hospital acquired pressure ulcers, which is a direct result of the improvement work undertaken. Over the coming year we plan to build on this improvement by:

- Maintain or reduce current levels of newly developed hospital acquired and deteriorating pressure ulcers;
- Working collaboratively with our partners as part of the Sustainability and Transformation Programme and the community;
- Expand the area of expertise to reduce the number of hospital acquired moisture lesions.

What do we want to achieve?

Following several years where the number of hospital acquired pressure ulcers had reduced, it was agreed that the local target for 2017/18 would be to maintain the levels of hospital acquired pressure ulcers reported in 2016/17. This was still considered an ambitious target in the context of the increasing demand and sicker patients.

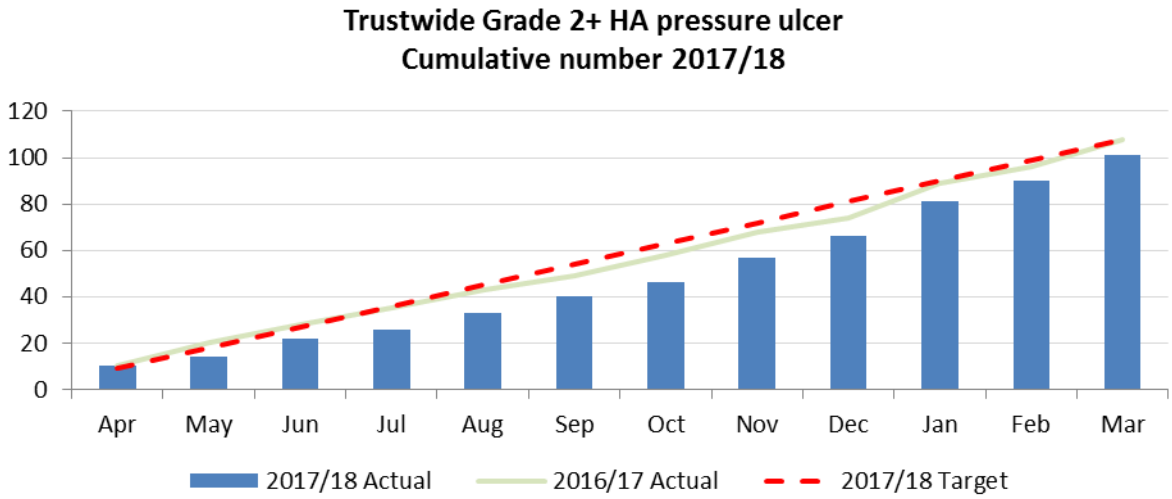
Performance to-date

Achievements and successes

Some of the key and more recent achievements and successes are:

- Development of a measurement strategy to track and communicate progress against goals from ward level to board level.
- Monthly review of pressure ulcer data, enabling education and feedback to target any issues promptly. Also established was a measurement of mucosal lesions which are reported separately from other incidents of pressure damage.
- Providing a dedicated tissue viability service to ward staff offering training and advice in the identification and management of pressure ulcers and wound care.
- Development of a protocol for non-compliance in adult patients, which has been incorporated into the Trust policy.
- Ensured root cause analysis is completed and is of quality on all grade three and above hospital acquired pressure ulcers, and that the duty of candour is completed.
- Providing regular pressure ulcer training and education to ward teams, as well as agreeing that all doctors and ward based physiotherapists should undertake e-learning to raise awareness across disciplines.
- Beginning collaborative working with Yeovil District Hospital NHS Foundation Trust and Somerset Partnership NHS Foundation Trust to align pressure ulcer root cause analysis and standardise investigations into pressure ulcer incidents.
- Collaborative development of a pressure ulcer leaflet for patients with learning disabilities.
- Established links between the tissue viability service at Taunton and Somerset NHS Foundation Trust and the community tissue viability service, which allows for improved discharge planning providing a more effective service and better outcome for patients.
- Participating in the Somerset Tissue Viability Collaborative which aims to share learning and best practice across the county and to develop a standardised approach to care. The group also provided a study day and training for nursing home and care agency staff.

- Rolling out a pressure ulcer checklist sticker to support staff to complete regular and complete skin inspection.
- Shared learning from pressure ulcer incidents throughout the Trust and with other healthcare providers.



This chart shows the cumulative number of hospital acquired pressure ulcers reported by month (blue bars). The green line represents the position from the previous year, and the red dashed line is the trajectory required to meet the target for the year.

How this will be measured and monitored?

All Trust-apportioned cases are investigated to identify learning, sharing this learning in the organisation and driving further improvements.

Group	Date of last hospital acquired pressure ulcer	Current gap (days)	Previous gap (days)	Longest gap (days)
Critical Care	15/02/2018	44	326	326
Head & Neck	28/03/2018	3	495	495
HOPE	18/01/2018	72	437	437
Women & Children	23/07/2015	982		982
Private	19/03/2017	377	247	377
Neuro Rehab	07/08/2017	236	424	598
Stroke	14/03/2018	17	695	695

QIP 2018/19 - Priority 3 - Mental health and holistic care

The aim of this priority is to increase staff capability to recognise and respond to those with mental health needs (children, adults in crisis, and older people). This will be measured by training compliance in conflict resolution, eating disorders, adolescent mental health e-learning and establishment of psychiatric liaison pathways.

Why is this important?

As identified in the recent National Confidential Enquiry in Patient Outcome and Death report (NCEPOD, 2017), *"Mental Health in General Hospitals: Treat as One"*, the benefits of integrating care across boundaries (e.g. health, social care, employment and housing) are understood. However, good integrated care for people with mental health conditions often appears to remain the exception rather than the rule, with physical healthcare and mental healthcare largely disconnected. This can lead to poor patient experience and reduced quality of care.

What do we want to achieve?

There is a limited amount of mental health training provision for staff at MPH. The NCEPOD report "Treat as One" (2017) explored the care given to mentally unwell patients in acute hospitals. The report highlighted many issues with the quality of care given to mentally unwell patients in this setting, and identified staff training as key to addressing some of them. The report found that:

a. Fewer than half of hospitals have mandatory training in the management of patients with mental health conditions.
b. No hospitals offer training covering all aspects of management of patients with mental health conditions.
c. Staff reported significant training gaps.

The action plan checklist arising from the NCEPOD report makes clear that enhanced training for staff is a key driver for obtaining improved care for patients.

The NHS Five Year Forward View for Mental Health also makes significant recommendations regarding mental health training for acute hospital staff. It says that "staff across the NHS need to have training that equips them to understand mental health problems and to treat people with mental health problems with dignity and respect." It recommends that core training be provided in:

- Basic mental health awareness and knowledge
- Understanding of mental health law
- Public mental health
- Compassion and communication skills.

The Trust's developing partnership with Somerset Partnership NHS Foundation Trust (the local provider of NHS mental health services) will mean closer working between physical and mental health care services. This will mean both a greater need and a greater opportunity for better mental health training for hospital staff.

Examples of action taken

The Trust has self-assessed against the NCEPOD action plan checklist. Although it is compliant against a number of the targets, there is a lack of compliance against others. Many improvements could be made were staff to have better skills in relation to the management of mental ill health.

There is a specific target in the action plan dealing with the need for all staff to be trained in mental health issues. However, in addition to this, better training of staff would help address other weaknesses in the service provided to those patients who are mentally unwell. For example:

a. There is only partial compliance in relation to the documentation of mental illness for patients presenting at the hospital (NCEPOD standard number 1). Improved education and training will help with this.

b. Better training will also reduce the reliance on expensive specialist staff to provide the necessary one-to-one nursing support for mentally ill patients (standard 10) by equipping our own staff with the ability to provide it instead.

c. Better training for staff will also help improve discharge planning and improve the ability of Musgrove Park Hospital's staff to contribute more fully to multi-disciplinary working (standard 15).

Performance to-date

Over the last year we have trained over 250 frontline care staff with enhanced knowledge and skills in supporting people with mental health conditions or distress.

Clinical links have also been built between the adult and children's wards in mental health and the acute Trust.

Until recently the Trust had a small liaison psychiatry service which provided input into the care of mentally unwell patients in the hospital but this was only offered for limited hours across the week. This service is provided by Somerset Partnership, and recently the service has been expanded as part of a targeted county-wide approach to improving care. The new enhanced service will be offered across the 24/7 period once all posts are fully recruited into.

What do we plan to do this year?

Over the coming year we plan to continue with a work plan to enhance knowledge and skills of the acute care workforce in caring for patients with mental health conditions or distress.

- Care collaborative– a national programme run by NHS Improvement aimed at enhancing the care of patients who are suffering from delirium, dementia or are distressed in the acute care environment. As part of this work we plan to introduce a trial of activity co-ordinators (to three elderly care wards) to facilitate increased mental and physical stimulation with the aim of reducing agitation. Staff, working in pilot areas, will be developed to encourage increased levels of activity and self-care.
- Integrating physical and mental health network – a national programme being run by the Kings Fund. The Trust is participating in this national programme alongside partners from mental health and local service users. This programme is aimed at developing and enhancing a seamless pathway from primary care across all care settings for those with mental health issues.
- Full roll-out of the psychiatric liaison service - as this team is fully recruited the enhanced service will offer greater care and experience for service users. The team will offer learning opportunities for current acute staff to better help them meet patients' needs.
- A programme of short work experience placements is being developed for staff working with acute adults and children in mental health settings, and return placements for mental health staff in the acute setting. This will be trialled during the year using a set of core competencies to enable staff to demonstrate their enhanced learning and skills.
- Training in knowledge and skills for caring for people with mental health conditions or distress will continue to be offered to an extended group of front line staff.

How this will be measured and monitored?

Progress on this work and the NCEPOD 'Treat as One' action plan will be monitored through an oversight group who will meet during the year to review progress and consider emerging opportunities or need.

Training numbers for formal courses will be monitored and feedback from exchange programmes will be sought to ensure a diverse qualitative narrative is built to evaluate staff experience.

Where we are participating in National programmes ('care collaborative' and 'integrating physical and mental health network') these will be formally evaluated as part of that programme and future practice developments planned from this evaluation.

QIP 2018/19 - Priority 4 - Patient experience

Why is this important?

It has been evidenced that co-design between staff and service users results in services that better meet patient expectations and are more cost effective and sustainable. Co-design is a key component of our ambitions to be an exemplar Trust for patient and family centred care and as such we want to support improvement projects to bring staff and users together and grow our confidence and skills in the co-design approach.

What do we want to achieve?

- Patient partners to be at each of the improvement boards supporting the prioritisation and decision making on which projects are supported.
- For each new improvement project to use co-design methodology bringing staff and patient users/representatives together from the outset.

To complete the Patient and Family Centred care baseline measure with the Musgrove Partners using the co-design approach.

Examples of action taken

Over the past year the patient experience team and improvement team have been working together to set the need for, and expectation of, partnership working with patient partners. The boards have been recruiting their partners and developing relationships and understanding.

The Musgrove Partners have co-designed their role outline and framework with the patient experience team and have initiated the co-design of the Patient and Family Centred care baseline measure tool(s)

How this will be measured and monitored?

1) Measure the patient involvement, influence and contribution to the improvement boards.
2) Measure the number of new improvement projects that use co-design methods.
3) Completion of the Patient and Family Centred Care Audit.

QIP 2018/19 - Priority 5 - Right care, right time, right place

Why is this important?

Co-ordination of care across Somerset is important to ensure that we can deliver sustainable care and continue to make improvements in the way we deliver that care in line with the joint Health and Social Care Strategy being developed by the Somerset Clinical Commissioning Group and Somerset County Council.

What do we want to achieve?

Much of the work around the five core service areas (urgent and emergency services, proactive care/elderly frail, planned care, children's and maternity services, and mental health and learning disability) is in the early stages of development, with consultation just beginning, but it builds on a number of key work streams that are already underway.

One of the key elements to make sure patients receive the right care, at the right time, in the right place is to continue our improvement work on discharge.

In 2018/19, we will consolidate the work achieved in 2017/18, including:

- Business case to sustainably fund **Home First, Red Cross discharge scheme and 7/7 discharge facilitators;**
- Continued work to support the effectiveness of **board rounds;**
- Professional support to embed **Home First**, and the culture of enablement in community hospitals and the care home selected;
- Launch of **enablement programmes** into acute wards in the hospital;
- Engagement in the **Enhanced Care Collaborative** to improve the quality of supervision of behaviourally challenged patients;
- Extension of **criteria led discharge** to a larger number of wards;
- Support for wards to apply the **reluctant discharge policy** when all other options are exhausted;
- Implementation of the **red bag scheme** to improve transfers between acute trusts and care homes;
- Improve the timeliness and quality of **discharge summaries** (Note – the requirement for all patients to have a timely and comprehensive discharge summary is monitored as part of our commissioners' contract)**;**
- Support honest conversations with patients at **the end of life**, and record these in Discharge Summaries;
- Pilot and roll out electronic **white boards** and **admission/ discharge/transfer apps** as part of the Digital Global Exemplar work.

How this will be measured and monitored?

This will be monitored via a number of audits and measures, building on the work done in 2017/18 (see report Priority 2 for 2017/18 earlier in the report), overseen by the Trust's discharge group.

QIP 2018/19 - Priority 6 - Staff retention and well being

Why is this important?

Staff retention continues to be a key issue. With workforce supply an ongoing challenge it is vital that both new and existing colleagues are supported and encouraged to remain within the health services in Somerset. Significant evidence demonstrates that retaining skills and competent colleagues improves patient experience, the overall quality of patient care and colleague satisfaction. There is no single solution to improve retention. However, crucial to retaining our colleagues is by supporting them as individuals through the provision of health and wellbeing activities. Health and wellbeing is now recognised as more than just a matter for individual attention. Successful organisations recognise that good health is a key enabler to good business. The health, safety and wellbeing of colleagues directly contributes to organisational success and poor workforce health has a high cost. We are committed to being an employer that promotes and supports the physical and psychological health and wellbeing and safety of our entire workforce.

What do we want to achieve?

The aim is to have an effective retention plan which balances the needs of our people wherever they are in their career and personal lives, which is based on a good understanding of what is happening and what needs to be done to maintain our colleagues working effectively to provide future focused healthcare in Somerset. Colleagues need to work in an environment where they are well managed, valued for their contribution and are developed.

Examples of action taken

The greatest impact on both retention and wellbeing will be through our managers and leaders. Key to this will be ensuring they are equipped to support and develop colleagues and create a positive environment where colleagues feel safe, valued, supported and empowered. This will be delivered through sustained leadership development, clear learning opportunities, succession planning, effective performance review processes, joint values and behaviours across the alliance, and actively promoting health and wellbeing.

Performance to-date

The health and wellbeing strategy has been developed and launched in March 2018, this strategy sets out how health, wellbeing and safety will be promoted and measured. The joint People Strategy for the alliance with Somerset Partnership NHS Foundation Trust, sets out how the people objectives will be delivered.

How this will be measured and monitored?

Measurement will be through a mixture of hard and soft measures, including regular monitoring of sickness absence, turnover, temporary staffing costs and usage, vacancy fill rates, national staff survey, pulse check, exit interviews and informal and formal feedback.

NATIONAL QUALITY INDICATORS

All data in this section is provided by the Health and Social Care Information Centre and is governed by standard national definitions.

Summary Hospital-Level Mortality Indicator (SHMI)
Related domain: (1) Preventing People from dying prematurely

The Summary Hospital-Level Mortality Indicator (SHMI) is a standardised mortality indicator. It expresses actual deaths compared to an expected value. In this case, 'average' is represented by a value of 1. SHMI has been designed to overcome certain shortcomings inherent in other standardised mortality indicators such as the HSMR. This includes the influence of coding of palliative care patients. SHMI also includes patients who died within 30 days of discharge whereas HSMR looks only at in hospital deaths.

The Trust's overall SHMI over the past three years is represented in the table below:

Reporting Period	Ratio (Banding)	England	Lowest Trust	Highest Trust
April 2017 to March 2018	Data due to be published September 2018			
January 2017 to December 2017	Data due to be published June 2018			
October 2016 to September 2017	0.9208	1.0000	0.7270	1.2473
July 2016 to June 2017	0.9344 (as expected)	1.0000	0.7261	1.2277
April 2016 to March 2017	0.9522 (as expected)	1.0000	0.7075	1.2123

January 2016 to December 2016	0.9844 (as expected)	1.0000	0.6907	1.1894
October 2015 to September 2016	0.9921 (as expected)	1.0000	0.6897	1.1638
July 2015 to June 2016	0.997 (as expected)	1.000	0.694	1.171
April 2015 to March 2016	1.002 (as expected)	1.000	0.678	1.178
January 2015 to December 2015	1.000 (as expected)	1.000	0.669	1.173
October 2014 to September 2015	0.983 (as expected)	1.000	0.652	1.177
July 2014 to June 2015	0.984 (as expected)	1.000	0.661	1.209
April 2014 to March 2015	0.970 (as expected)	1.000	0.670	1.210
January 2014 to December 2014	0.967 (as expected)	1.000	0.655	1.240
October 2013 to September 2014	0.982 (as expected)	1.000	0.597	1.198
July 2013 to June 2014	0.984 (as expected)	1.000	0.541	1.198
April 2013 to March 2014	0.967 (as expected)	1.000	0.539	1.197

NB: 1.00 is the SHMI average, values lower than 1.00 indicated better than average.

The Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- There has been continued focus on initiatives related to safety that have reduced the number of avoidable deaths in a range of specialities.
- Routine review of Healthcare Evaluation Data (HED) by speciality, procedure and diagnosis groups has provided early warning of problems in patient care.

The Taunton and Somerset NHS Foundation Trust intends to take the following actions to improve on this rate, and so the quality of its services:

- By regularly monitoring outcomes through tools such as Healthcare Evaluation Data.
- By identifying where outcomes appear to be deviating. This allows the Trust to investigate and verify the result and give an early opportunity to make improvements to patient treatment pathways.

Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) performance are reported each month to the Trust Board, but due to considerable monthly variation a rolling three-month figure is reported. Weekday versus weekend non-elective admissions is also reported.

Additional scrutiny is undertaken via the Trust's monthly mortality surveillance group and the SHMI and HSMR, split by diagnostic group, is kept under close review. This often prompts engagement with the clinical leadership who give consideration to data and clinical quality, as appropriate.

Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust

Reporting Period	TST	England	Lowest Trust	Highest Trust
April 2017 to March 2018	Data due to be published September 2018			
January 2017 to December 2017	Data due to be published June 2018			
October 2016 to September 2017	21.3%	31.5%	11.5%	59.8%
July 2016 to June 2017	20.1%	31.1%	11.2%	58.6%
April 2016 to March 2017	18.5%	30.7%	11.1%	56.9%
January 2016 to December 2016	19.0%	30.1%	7.3%	55.9%
October 2015 to September 2016	18.6%	29.7%	0.4%	56.3%
July 2015 to June 2016	18.4%	29.2%	0.6%	54.8%
April 2015 to March 2016	17.0%	28.5%	0.6%	54.6%
January 2015 to December 2015	13.8%	27.6%	0.2%	54.7%
October 2014 to September 2015	12.5 %	26.6%	0.2%	53.5%
July 2014 to June 2015	12.4%	26.0%	0.0%	52.9%
April 2014 to March 2015	13.4%	25.7%	0.0%	50.9%
January 2014 to December 2014	14.3%	25.7%	0.0%	48.3%
October 2013 to September 2014	14.5%	25.3%	0.0%	49.4%

July 2013 to June 2014	10.7%	24.6%	0.0%	49.0%
April 2013 to March 2014	6.4%	23.6%	0.0%	48.5%

The Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reason:

- The national standard for coding states to add the palliative care code whenever the palliative care team have been involved in the patient's episode of care. From November 2016 we have included the palliative care code for admissions where the patient has an assessment completed and is on a pathway, as these have been specifically designed by the palliative care team to support clinicians in delivering high quality palliative care.

The Taunton and Somerset NHS Foundation Trust intends to take the following actions to improve on this rate, and the quality of its services by:

- monitoring palliative care rates at the mortality surveillance group meeting;
- auditing palliative care coding to ensure all admissions with assessment completed is coded; and
- continuously auditing the use of the end of life care pathway for patients who die.

PROMS: PATIENT REPORTED OUTCOME MEASURES

Related Domain (3) Helping people to recover from episodes of ill health or following injury

PROMs measure a patient's health status or health-related quality of life from their perspective. Typically, this is based on information gathered from a questionnaire that patients complete before and after surgery. The figures in the following tables show the percentages of patients reporting an improvement in their health-related quality of life following four standard surgical procedures, as compared to the national average.

**data suppressed (not enough responses)*

Groin hernia surgery (EQ-5D Index)

Reporting Period	Adjusted average health gain	England	Lowest Trust	Highest Trust
April 2017 to September 2017	*	0.089	0.055	0.140
April 2016 to March 2017	0.077	0.087	-0.009	0.135
April 2015 to March 2016	0.076	0.088	0.021	0.157
April 2014 to March 2015	0.063	0.084	0.000	0.154
April 2013 to March 2014	0.097	0.085	0.008	0.139
April 2012 to March 2013	0.113	0.085	0.015	0.157
April 2011 to March 2012	0.075	0.087	-0.002	0.143
April 2010 to March 2011	0.075	0.085	-0.020	0.156

Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- The Taunton and Somerset NHS Foundation Trust adjusted average health gain is within the expected range.

Taunton and Somerset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by

- Providing a full pre-operative assessment service to enable early identification of problems for management prior to admission for surgery and a range of verbal and written information about the procedure.
- Monitoring the adjusted average health gain through the Trust Data Outlier Review Meeting and sharing with the clinical and management teams.

Varicose vein surgery (EQ-5D Index)

Reporting Period	Adjusted average health gain	England	Lowest Trust	Highest Trust
April 2017 to September 2017	*	0.096	0.068	0.134
April 2016 to March 2017	0.085	0.092	0.015	0.154
April 2015 to March 2016	0.075	0.096	0.018	0.150

April 2014 to March 2015	0.130	0.094	-0.009	0.154
April 2013 to March 2014	0.095	0.093	0.023	0.150
April 2012 to March 2013	0.119	0.093	0.023	0.175
April 2011 to March 2012	0.090	0.094	0.047	0.167
April 2010 to March 2011	0.086	0.091	-0.007	0.155

Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- Taunton and Somerset NHS Foundation Trust adjusted average health gain is within the expected range.

The Taunton and Somerset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by

- Monitoring the adjusted average health gain through the Trust Data Outlier Review Meeting and sharing with the clinical and management teams.

Primary hip replacement surgery (EQ-5D Index)

(2016/17 finalised data June 2018)

Reporting Period	Adjusted average health gain	England	Lowest Trust	Highest Trust
April 2017 to September 2017	*	0.465	0.472	0.472
April 2016 to March 2017	0.434	0.445	0.310	0.537
April 2015 to March 2016	0.451	0.438	0.320	0.512
April 2014 to March 2015	0.464	0.436	0.331	0.524
April 2013 to March 2014	0.414	0.436	0.342	0.545
April 2012 to March 2013	0.460	0.438	0.128	0.315
April 2011 to March 2012	0.407	0.416	0.306	0.532
April 2010 to March 2011	0.415	0.405	0.264	0.503

Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- The Taunton and Somerset NHS Foundation Trust adjusted average health gain is within the expected range.

The Taunton and Somerset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by

- Monitoring the adjusted average health gain through the Trust Data Outlier Review Meeting and sharing with the clinical and management teams.

- Improving our participation rate by giving more patients to the opportunity to take part in PROMS.

Primary knee replacement surgery (EQ-5D Index)

(2016/17 finalised data due June 2018)

Reporting Period	Adjusted average health gain	England	Lowest Trust	Highest Trust
April 2017 to September 2017	*	0.328	0.289	0.368
April 2016 to March 2017	0.332	0.324	0.242	0.404
April 2015 to March 2016	0.320	0.320	0.198	0.398
April 2014 to March 2015	0.330	0.315	0.204	0.418
April 2013 to March 2014	0.277	0.323	0.215	0.416
April 2012 to March 2013	0.337	0.319	0.195	0.409
April 2011 to March 2012	0.316	0.302	0.180	0.385
April 2010 to March 2011	0.280	0.299	0.176	0.407

The Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- The Taunton and Somerset NHS Foundation Trust adjusted average health gain is within the expected range.

The Taunton and Somerset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by

- Monitoring the adjusted average health gain through the Trust Data Outlier Review Meeting and sharing with the clinical and management teams.

READMISSIONS

Patients readmitted to a hospital within 28 days of being discharged

Related Domain (3) Helping people to recover from episodes of ill health or following injury

Whilst some emergency readmissions following discharge from hospital are an unavoidable consequence of the original treatment, others could potentially be avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning and support for self-care. Because of the complexities in collating data, national and local rates are significantly in arrears. It should also be noted that a readmission is counted for a patient within the 28 day period, even if it is for an entirely different problem, eg a discharge following a hip replacement and readmission due to a stroke.

This report includes information about children re-admitted to the Trust which show that they are broadly in line with the national average. Our adult readmission results for 2011/12 indicate that we were significantly better than average. Our 28 day readmission index is 105% which is well within the confidence limits. There are five diagnoses that are significantly above the expected range but these are small samples and none has reached significance, but we will continue to monitor and evaluate the data.

Percentage of patients aged 0 – 15 readmitted to the Trust within 28 days of being discharged

Note: Benchmark data relates to Medium Acute Trusts

Reporting Period	Percentage	England	Lowest Trust	Highest Trust
April 2011 to March 2012	10.54%	10.04%	0.00%	13.58%
April 2010 to March 2011	10.43%	9.87%	0.00%	13.78%
April 2009 to March 2010	9.75%	10.13%	0.00%	14.20%
April 2008 to March 2009	10.11%	10.14%	0.00%	17.34%

Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust tends to accept a higher readmission rate because of its strategy to manage as many cases as possible as 'ambulatory' in order to minimize overall admission and length of stay.

- The Trust operates an open admission list system – there are approximately 100 children on the open admission list who have a chronic condition, e.g. epilepsy, chronic heart conditions and haematological conditions. These children have had consultant approval to attend the children's unit in accordance with condition requirements. Open admission can be an ongoing process throughout the child's life.

- Children with life limiting conditions, such as oncology related disorders and immune compromising disorders, have repeated admissions due to medical management of their condition.

Taunton and Somerset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by:

- Reducing the number of ward reviews where appropriate.

- Implementation of the new community midwifery-led feeding protocol and assessment to prevent admissions for 'poor feeding', initially reduced inpatient admissions with a period of only two admissions per month for the first six months. Subsequent months have shown a slight rise with on average four a month being managed as an inpatient. It is noted that these admissions are the more complex cases with additional complications in addition to poor feeding.

- Regular assessment of the reasons for admission to ensure that, within specialities and conditions, there are no trends apparent or evidence of readmissions indicating a problem in clinical treatment or processes.

Percentage of patients aged 16 or over readmitted to the Trust within 28 days of being discharged

Note: Benchmark data relates to Medium Acute Trusts

Reporting Period	Percentage	England	Lowest Trust	Highest Trust
April 2011 to March 2012	10.61%	11.26%	0.00%	13.50%
April 2010 to March 2011	10.06%	11.17%	0.00%	13.00%
April 2009 to March 2010	9.77%	11.06%	0.00%	13.30%
April 2008 to March 2009	10.12%	10.82%	0.00%	13.08%

Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

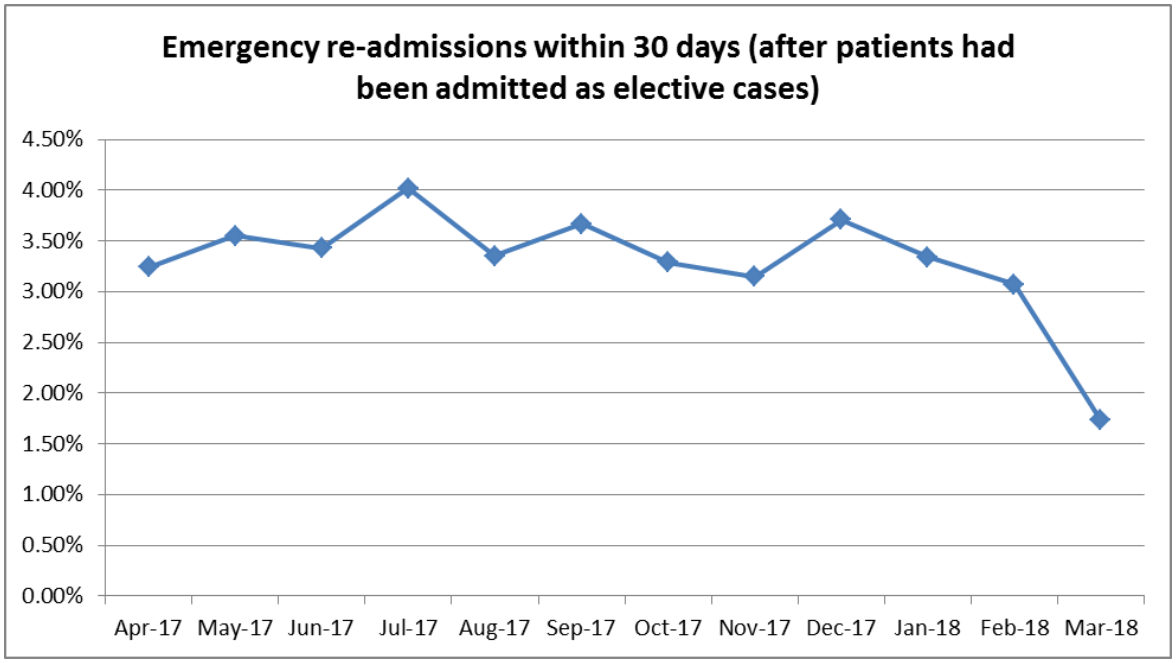
- over a period of three years, the Trust has maintained an overall 28 day readmission rate of 0-2% below the national average for equivalent hospitals.
- this is indicative of good general care and appropriate clinical judgment with regards to patient discharges.
- this is during a period of the stepwise introduction of enhanced recovery programmes in various specialties, which would indicate that appropriate discharge criteria are being maintained.

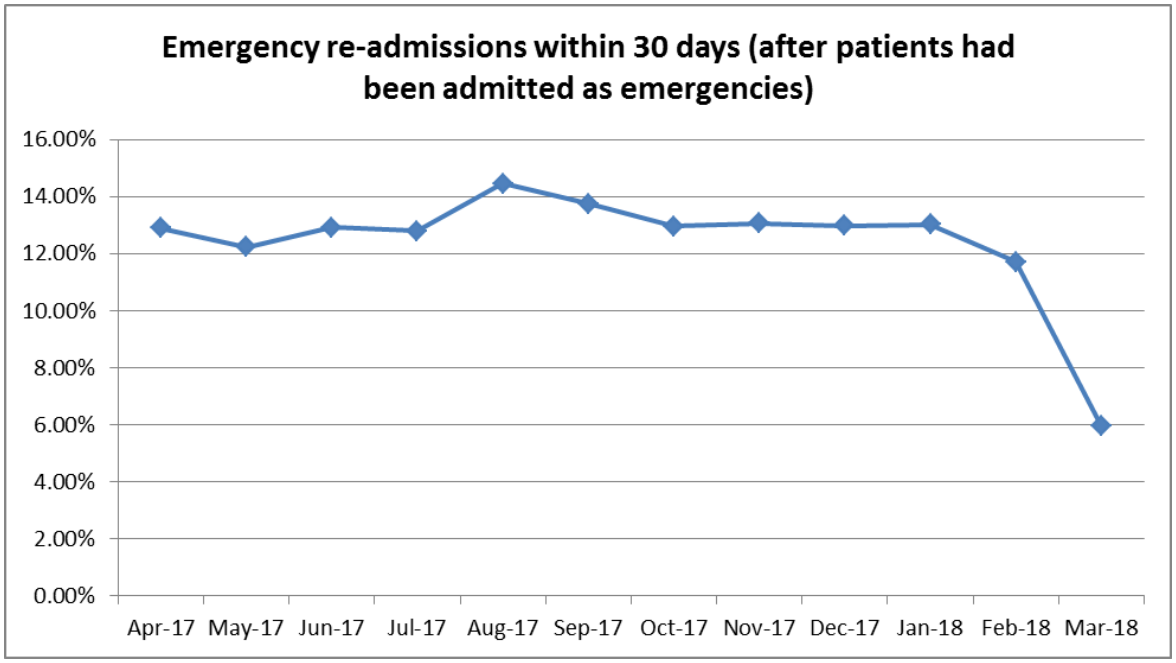
Taunton and Somerset NHS Foundation Trust intends to continue to try to improve readmission rates, and so the quality of its services, by:

- Continuing to monitor readmission rates for various procedures and conditions, as this can provide information about clinical teams in greater detail. This would allow improvements to be directed at the areas that most require them.
- Increased use of ambulatory care and urgent clinics to manage emergency care pathways.
- Management of groups of patients as ward attenders through MAU and SAU as an alternative to admission where appropriate.
- Working with other health and care providers in Somerset to ensure alternatives to admission are accessed where appropriate.

***NOTE** – although this indicator remains one of the indicators that the Trust is required to report on, recent data beyond 2012 is not available from the Health and Social Care Information Centre. In line with the change in national focus on readmission rates, the Trust is currently undertaking analysis to understand the differences in readmission rates within seven days of discharge, by day of week of discharge from hospital.*

The graphs below show the overall rate of readmission for patients during 2017/18. The figures are based on those patients readmitted within 30 days of discharge, split between those admitted for elective care (i.e. for a planned procedure) and those admitted as an emergency.





RESPONSIVENESS TO THE PERSONAL NEEDS OF PATIENTS

(INPATIENT OVERALL PATIENT EXPERIENCE SCORE)

Related Domain (4) Ensuring that people have a positive experience of care
Patient experience is a key measure of the quality of care.

Data for 2017/18 will not be published until May/June 2018

Reporting Period	Score	England	Lowest Trust	Highest Trust
2016/17	80.0 (19th/149 trusts included)	76.7	70.7	88.0
2015/16	80.2	77.3	70.6	88.0
2014/15	81.1	76.6	67.4	87.4
2013/14	80.8	76.9	67.1	87.0
2012/13	79.0	76.5	68.0	88.2
2011/12	78.3	75.6	67.4	87.8
2010/11	79.4	75.7	68.2	87.3
2009/10	77.8	75.6	68.6	86.0
2008/09	78.6	76.0	68.1	87.6
2007/08	77.5	75.3	66.8	86.5
2006/07	78.6	75.7	67.7	87.2

Data Source: Hscic.gov.uk Indicator 4b patient experience of hospital care

Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust scores consistently better than the national average due to the emphasis placed on listening to and learning from patient feedback.
- A focus on improvement with patient experiences a key part of that work.

Taunton and Somerset NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services, by:

- Focus on increasing the response rates to the surveys, which include the Friends and Family question.
- Complete Patient Experience Collaboration project and learning around real-time measurement.
- Continuing to ensure the visibility of the results at directorate and board level on a monthly basis.
- Build on work initiated to make learning from patient experience a key part of the improvement boards.

Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)

Reporting Period	Taunton and Somerset	England	Lowest Acute Trust	Highest Acute Trust
January - March 2018	Data due to be published in June 2018			
October - December 2017	95.36%	94.28%	76.08%	100.00%
July - September 2017	94.24%	95.25%	71.88%	100.00%
April - June 2017	95.06%	95.20%	51.38%	100.00%
January - March 2017	95.53%	94.71%	63.02%	100.00%
October - December 2016	94.76%	95.64%	76.48%	100.00%
July - September 2016	93.89%	95.51%	72.14%	100.00%
April - June 2016	93.74%	95.73%	80.61%	100.00%
January - March 2016	91.18%	95.53%	78.06%	100.00%
October - December 2015	92.88%	95.48%	61.47%	100.00%
July - September 2015	95.64%	95.86%	75.04%	100.00%
April - June 2015	95.47%	96.04%	86.08%	100.00%
January - March 2015	94.74%	95.97%	79.23%	100.00%
October - December 2014	94.24%	95.96%	81.19%	100.00%
July - September 2014	94.69%	96.19%	86.36%	100.00%
April - June 2014	95.36%	96.16%	87.25%	100.00%
January - March 2014	95.56%	96.00%	78.86%	100.00%
October - December 2013	95.18%	95.84%	77.70%	100.00%
July - September 2013	95.45%	95.74%	81.70%	100.00%
April - June 2013	95.28%	95.45%	78.78%	100.00%

The Trust considers that this data is as described for the following reasons:

- Medical staff receive training as part of the induction programme in the protocol for risk assessment. This applies when patients are admitted as emergencies as well as for planned procedures.
- The data correlates with other sources of information such as the NHS Safety Thermometer and the root cause analysis completed for cases of hospital acquired VTE.

The Trust intends to take the following action to improve this rate, and the quality of its services, by:

- Continuing to report this data on a weekly basis across the Trust.
- Continuing to focus on improving the data collection on the wards and departments with low compliance.

Rate of Clostridium *difficile* infection

Related Domains (5) Treating and caring for people in a safe environment and protecting them from avoidable harm.

Clostridium *difficile* infection (CDI) can cause diarrhoea and sometimes severe inflammation of the bowel. It can occur when the normal bacteria in the gut are disturbed, usually by taking antibiotics. Although not all cases are preventable, CDI Trust-attributed rates (measured per 100,000 bed days) are an important indicator of improvement in protecting patients from avoidable harm and provide a useful tool for making comparisons between organisations and tracking improvements over time.

Reporting Period	TSFT Trust-apportioned CDI rate per 100,000 bed days	National Average (England)	Lowest Acute Trust	Highest Trust
April 2017 – March 2018	CDI Trust-attributed rates for 2017/18 will not be available until August, but are expected to be below the national average.			
April 2016 – March 2017	*5.6*	*13.2*	*0.0*	*82.7*
April 2015 – March 2016	*13.8*	*14.9*	*0.0*	*66.0*
April 2014 – March 2015	7.4	15.1	0.0	62.2
April 2013 - March 2014	7.5	14.7	0.0	37.1
April 2012 - March 2013	10.4	17.3	0.0	30.8
April 2011 - March 2012	20.3	22.2	0.0	58.2
April 2010 - March 2011	41.1	29.6	0.0	71.8
April 2009 - March 2010	27.2	36.7	0.0	85.2

Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- Since 2012, the Trust has had consistently lower rates than the national average. This is the result of sustaining the bundle of improvements implemented in 2011, which included prompt isolation of patients, high standards of cleaning, reductions in the use of high-risk antibiotics and

regular review of patients with CDI by a microbiologist and the Infection Prevention and Control Team.

- The CDI rate for 2017/18 is not yet known. Although there has been an increase in the number of cases compared to last year, rates are still expected to be below the national average rate.

Taunton and Somerset NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services, by:

- Continuing to investigate all Trust-apportioned cases to identify learning, sharing this learning in the organisation and driving further improvements.
- Continuing to reduce the CDI risk associated with antibiotic treatment through robust antibiotic stewardships and further review of antimicrobial guidance, where appropriate.
- Prompt isolation of all symptomatic patients and also previous CDI cases, where there is an increased risk of reoccurrence
- Giving scrupulous attention to hand hygiene, decontamination and cleaning practices.

Patient safety incidents reported to the National Reporting and Learning System

The National Reporting and Learning System (NRLS) collects and collates information from the incident databases of health service providers to provide thematic review and share wider learning about patient safety through a system of safety alerts sent to every organisation.

The Trust's Safeguard Incident software has an automatic process for uploading its incidents to the National Learning and Reporting System (NRLS). There is evidence of increasing numbers of reports being uploaded to the NRLS database, as indicated in the table below:

Reporting Period	Number of Incidents Reported	Rate per 1000 Bed Days			
		Taunton and Somerset	Median for Acute (Non-Specialist) Trusts	Lowest Trust	Highest Trust
Apr 2017 – Sep 2017	2,985	39.9	41.7	23.5	111.7
Oct 2016 – Mar 2017	3,334	44.4	40.1	23.1	69.0
Apr 2016 – Sep 2016	3,251	44.9	40.0	21.2	71.8

Reporting Period	Number of Incidents Reported	Rate per 1000 Bed Days			
		Taunton and Somerset	Median for Acute (Non-Specialist) Trusts	Lowest Trust	Highest Trust
Oct 2015 – Mar 2016	3,156	41.7	39.3	14.8	75.9
Apr 2015 – Sep 2015	2,987	40.3	38.3	18.01	74.67
Oct 2014 – Mar 2015	3,171	36.0	35.3	3.6	82.2
Apr 2014 – Sep 2014	3292	38.2	35.1	0.2	74.96
Oct 2013 – Mar 2014	3116	35.9	32.4	5.8	74.9
Apr 2013 – Sep 2013	3004	6.95	7.2	3.5	14.5
Oct 2012 – Mar 2013	3010	7.0	7.0	1.7	16.7
Apr 2012 – Sep 2012	2342	5.48	6.7	3.1	14.4

The Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- We actively encourage reporting of incidents to enable learning to be obtained;
- The Trust has been involved in a range of work-streams led by our in-house Improvement Network to improve specific aspects of patient safety and to reduce incidents;
- We have continually reviewed and improved our systems for reviewing and uploading incidents to the NRLS to ensure that they meet the data quality requirements, resulting in a higher proportion of incidents being successfully uploaded to the NRLS.

The Taunton and Somerset NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services, by:

- Continuing to improve direct feedback to individuals and demonstrating clear learning outcomes from incidents reported the Trust hopes to further encourage staff to report.
- simplifying all processes relating to reporting incidents and concerns as part of the response to the “Freedom to Speak Up” report.

Number of patient safety incidents that resulted in severe harm or death

The NHS National Patient Safety Agency (NPSA) provided the following definitions for severe harm or death:

- Severe – Any unexpected or unintended incident which caused permanent or long-term harm, to one or more persons.
- Death – Any unexpected or unintended incident which caused the death of one or more persons.

Reporting Period	Number of Severe Harm / Death Incidents Reported	% of Total Incidents			
		Taunton & Somerset	Average for Acute (Non-Specialist) Trusts	Lowest Trust	Highest Trust
Apr 2017 – Sep 2017	2	0.1%	0.3%	0%	2.0%
Oct 2016 – Mar 2017	2	0.1%	0.3%	0%	2.1%
Apr 2016 – Sep 2016	7	0.2%	0.4%	0%	1.7%
Oct 2015 – Mar 2016	9	0.3%	0.4%	0%	2.0%
Apr 2015 – Sep 2015	5	0.2%	0.4%	0%	2.9%
Oct 2014 – Mar 2015	12	0.3%	0.5%	0%	6.2%
Apr 2014 – Sep 2014	11	0.3%	0.5%	0%	82.9%
Oct 2013 – Mar 2014	7	0.2%	0.7%	0%	2.3%
Apr 2013 – Sep 2013	3	0.1%	0.7%	0%	3.1%
Oct 2012 – Mar 2013	12	0.4%	0.6%	0%	4.8%
Apr 2012 – Sep 2012	4	0.2%	0.7%	0%	3.6%

The Taunton and Somerset NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has continually been significantly below the median for the % of incidents that cause serious harm or death, in line with several streams of patient safety work started in 2007.
- Patient safety work-streams have focused successfully on reducing serious incidents related to delays in escalation for treatment and patient falls.

The Taunton and Somerset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by

- A range of work-streams to improve specific aspects of patient safety and to reduce incidents.
- Improvements have also been made in the quality and general approach to investigation, giving more credibility to the recommendations which means better clinician engagement with the improvement agenda.
- Encouraging reporting of incidents and near misses and greater consistency in the rating of incidents.

STAFF, FRIENDS AND FAMILY

- The Staff, Friends and Family test has been carried out since April 2014. The test comprises two questions, 'How likely are you to recommend this organisation to friends and family if they needed care or treatment?' and, 'How likely are you to recommend this organisation to friends and family as a place to work?'.
- Colleagues are asked whether they are: 'extremely likely'; 'likely'; 'neither likely nor unlikely'; 'unlikely'; 'extremely unlikely'; or 'don't know'. The extremely likely and likely responses are added together and compared with the extremely unlikely and unlikely in calculating the results which are then benchmarked against other providers of this test nationally.
- The figures are shown against the national average in the table below. National figures are not available for Quarter 3.

Percentage of staff responding to the question 'How likely are you to recommend this organisation to friends and family if they needed care or treatment?':

	Trust Score		National Average	
	% Recommend	% Not Recommend	% Recommend	% Not Recommend
Quarter 1 (April - June 2017)	94%	1%	81%	6%
Quarter 2 (July - September 2017)	96%	1%	80%	6%
Quarter 4 (January - March 2018)	Figures not available until after publication			

Percentage of staff responding to the question 'How likely are you to recommend this organisation to friends and family as a place to work?':

	Trust Score		National Average	
	% Recommend	% Not Recommend	% Recommend	% Not Recommend
Quarter 1 (April - June 2017)	77%	8%	64%	17%
Quarter 2 (July - September 2017)	83%	6%	63%	19%
Quarter 4 (January - March 2018)	Figures not available until after publication			

The annual national NHS staff survey was carried out during Quarter 3 and provides the responses rather than the Staff, Friends and Family test. The results are shown against the national average in the following table:

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 and friends:

Reporting Period	Score	Average (Non-specialist acute Trusts)	Lowest Trust	Highest Trust
2017	Figures to be published on 24 May 2018			
2016	84%	70%	49%	85%
2015	82%	70%	46%	89%
2014	78%	65%	38%	89%
2013	78%	64%	40%	89%
2012	72%	62%	35%	89%
2011	74%	62%	33%	89%
2010	69%	63%	38%	89%

-

- The Trust scores well in both questions on the Staff, Friends and Family test, resulting in the Trust continuing to remain significantly above the national average. Contributing to this position has been the continuing delivery of the people strategy, leadership development and colleague engagement supported by directorate-led regular measurement and action planning.

STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2017/18 Taunton and Somerset NHS Foundation Trust provided, or sub-contracted, 79 relevant health services, including a comprehensive range of medical, surgical and specialist services in the following areas:

- Acute adult and paediatric care
- Maternity services
- Accident and Emergency treatment
- Diagnostic services
- Elective and emergency services
- Cancer care and radiotherapy.

Taunton and Somerset NHS Foundation Trust has reviewed all the data available to it on the quality of care in each of these relevant services.

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

The Trust is engaged with NHS England and NHS Improvement regarding the implementation of the priority clinical standards for 7-day hospital services. There is regular performance monitoring against the standards, with a working group led by the Chief Medical Officer, charged with ensuring good performance. The Trust has participated fully in the national performance audits, which have shown full compliance with some areas of the priority standards, and highlighted areas where compliance has not yet been achieved. There is an action plan in place to achieve improvements, which includes linking to the Trust's Global Digital Exemplar work. The action plan forms the framework for regular discussions with NHS England and NHS Improvement on these issues. Both organisations are engaged and informed about the Trust's progress, and of nationally-shared issues for compliance such as the need for significant investment in consultant resource to achieve some of the standards. There is also a good working relationship on 7-day Services with NHS Somerset and other local providers, including the sharing of information and good practice.

INFORMATION ON PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

National Clinical Audit Participation

During 2017/18, 47 national clinical audits and two national confidential enquiries covered relevant health services that Taunton and Somerset NHS Foundation Trust provides.

During that period Taunton and Somerset NHS Foundation Trust participated in 45/47 (96%) national clinical audits and 2/2 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that Taunton and Somerset NHS Foundation Trust were eligible to participate in during 2017/18 are as follows:

National Audit Title	Partic-ipated	Coverage	Notes (where applicable)
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) - National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	100%	To date
BAUS Urology Audits: Nephrectomy - British Association of Urological Surgeons	Yes	100%	
BAUS Urology Audits: Percutaneous Nephrolithotomy - British Association of Urological Surgeons	Yes	100%	
BAUS Urology Audits: Female stress urinary incontinence - British Association of Urological Surgeons	Yes	100%	
Bowel Cancer (NBOCAP) - Royal College of Surgeons of England	Yes	100%	
Cardiac Rhythm Management (CRM) -National Institute for Cardiovascular Outcomes Research	Yes	100%	

National Audit Title	Partic-ipated	Coverage	Notes (where applicable)
(NICOR)			
Case Mix Programme (CMP) Intensive Care - National Audit Research Centre (ICNARC)	Yes	100%	
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI) (NICOR)	Yes	100%	
Diabetes (Paediatric) (NPDA) - Royal College of Paediatrics and Child Health	Yes	100%	
Elective Surgery (National PROMs Programme) - NHS Digital	Yes	78%	
Endocrine and Thyroid National Audit - British Association of Endocrine and Thyroid Surgeons	Yes	100%	
Falls Audit	Yes	100%	
Hip Fracture Database	Yes	100%	
Fractured Neck of Femur - Royal College of Emergency Medicine	Yes	100%	
Head and Neck Cancer Audit (HANA) Saving Faces - The Facial Surgery Research Foundation	Yes	100%	
Inflammatory Bowel Disease (IBD) Programme - Inflammatory Bowel Disease Registry	Yes	100%	
Learning Disability Mortality Review Programme (LeDeR) - University of Bristol	Yes	100%	
Major Trauma Audit - The Trauma Audit and Research Network (TARN)	Yes	100%	
Maternal, Newborn and Infant	Yes	100%	

National Audit Title	Partic-ipated	Coverage	Notes (where applicable)
Clinical Outcome Review Programme MBRRACE-UK - National Perinatal Epidemiology Unit, University of Oxford			
National Audit of Breast Cancer in Older Patients (NABCOP) Clinical Effectiveness Unit - The Royal College of Surgeons of England	Yes	100%	
National Audit of Dementia - Royal College of Psychiatrists	Yes	100%	(Spot light audit on delirium)
National Bariatric Surgery Registry (NBSR) - British Obesity and Metabolic Surgery Society (BOMSS)	Yes	100%	
National Cardiac Arrest Audit (NCAA) -Intensive Care National Audit and Research Centre (ICNARC)	Yes	100%	
National Chronic Obstructive Pulmonary Disease Audit Programme -(COPD) Royal College of Physicians	Yes	100%	
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD) - Royal College of Physicians: Pulmonary Rehabilitation	Yes	100%	
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI) - London North West Healthcare NHS Trust	Yes	100% *	*data is pulled from HES, TARN and UKROC submissions
National Comparative Audit of Blood Transfusion Programme - NHS Blood and Transplant: Transfusion Associated Circulatory Overload	Yes	100%	

National Audit Title	Partic-ipated	Coverage	Notes (where applicable)
(TACO)			
National Diabetes Audit - Adults NHS Digital	Yes	100%	
National Audit of Inpatient Diabetes (NADIA)	Yes	100%	
National Pregnancy in Diabetes Audit (NPID)	Yes	100%	
National Diabetes Foot Care Audit	Yes	100%*	*small number of cases as primary care service in place
National Diabetes Transition Audit	Yes	100%*	*data is pulled from NPDA and NDA submissions
National Emergency Laparotomy Audit (NELA) - Royal College of Anaesthetists	Yes	100%	NELA year 5, this is still in progress
National Heart Failure Audit - National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	100%	To date
National Joint Registry (NJR)	Yes	100%	To date
National Lung Cancer Audit (NLCA) Royal College of Physicians	Yes	100%	
National Maternity and Perinatal Audit -Royal College of Obstetricians and Gynaecologists	Yes	100%	
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care) - Royal College of Paediatrics and Child Health	Yes	100%	
National Vascular Registry - Royal College of Surgeons of England	Yes	100%	To date

National Audit Title	Partic-ipated	Coverage	Notes (where applicable)
Oesophago-gastric Cancer (NAOGC) -Royal College of Surgeons of England	Yes	100%	
Pain in Children - Royal College of Emergency Medicine	Yes	100%	
Procedural Sedation in Adults (Care in Emergency Departments) - Royal College of Emergency Medicine	Yes	100%	
Prostate Cancer - Royal College of Surgeons of England	Yes	100%	To date
Sentinel Stroke National Audit Programme (SSNAP) - Royal College of Physicians	Yes	100%	To date
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme Serious Hazards of Transfusion	Yes	100%	To date
UK Parkinson's Audit Parkinson's UK	Yes	100%	

National audits falling outside the scope of the Trust's services

These projects were active within the period but relate to service types other than those the Trust provides, included for completeness:

National Audit Title	Partic-ipated	Coverage	Notes
Adult Cardiac Surgery - National Institute of Cardiovascular Outcomes Research (NICOR)	No	No	Not performed at this Trust
Adult Community Acquired Pneumonia -British Thoracic Society	No	n/a	Did not happen in this time period
BAUS Urology Audits: Cystectomy -	No	No	Not performed at

British Association of Urological Surgeons			this Trust
BAUS Urology Audits: Radical prostatectomy - British Association of Urological Surgeons	No	No	Not performed at this Trust
BAUS Urology Audits: Urethroplasty -British Association of Urological Surgeons	No	No	Not performed at this Trust
Congenital Heart Disease (CHD) - National Institute for Cardiovascular Outcomes Research (NICOR)	No	No	Not performed at this Trust
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Homicide (NCISH)	No	No	Mental health trust audit
National Audit of Anxiety and Depression TBC – to be commissioned by HQIP in 2017	No	No	Mental health trust audit
National Audit of Intermediate Care (NAIC) - NHS Benchmarking Network	No	No	Advised not to participate by Somerset CCG
National Audit of Psychosis TBC – to be commissioned by HQIP in 2017	No	n/a	Mental health trust audit
Neurosurgical National Audit Programme - Society of British Neurological Surgeons	No	No	Not performed at this Trust
Non-Invasive Ventilation (Adults) - British Thoracic Society	No	n/a	Did not happen in this time period
National Ophthalmology Audit - The Royal College of Ophthalmologists	No	n/a	Intended to participate in 2017, IT issues being overcome, to commence after March 2018
Paediatric Asthma British Thoracic	No	n/a	Did not happen in

Society			this time period
Paediatric Intensive Care (PICANet) -University of Leeds	No	No	Not relevant to us as not a stand-alone unit
Paediatric Pneumonia - British Thoracic Society	No	n/a	Did not happen in this time period
Pleural Procedures - British Thoracic Society	No	n/a	Did not happen in this time period
Prescribing Observatory for Mental Health (POMHUK) - Royal College of Psychiatrists	No	No	Mental health trust audit
Smoking Cessation - British Thoracic Society	No	n/a	Did not happen in this time period
National Audit of Rheumatoid and Early Inflammatory Arthritis – (TBC) to be commissioned by HQIP in 2017	No	n/a	Did not happen in this time period
National Audit of Seizures and Epilepsies in Children and Young People – (TBC) to be commissioned by HQIP in 2017	No	n/a	Did not happen in this time period
National End of Life Care Audit TBC – to be commissioned by HQIP in 2017	No	n/a	Did not happen in this time period

National Confidential Enquiries with active participation during 2017/18

Name of Confidential Enquiry	Coverage	Notes
Acute Heart Failure Study	100%	
Peri-operative Management of Surgical Patients with Diabetes	100%	

THE TRUST'S RESPONSE TO NATIONAL AND LOCAL AUDIT FINDINGS

National clinical audit

The reports of 22 national clinical audits were reviewed by the provider in 2017/18 and Taunton and Somerset NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

(NOTE: Action plans are developed for all audits where significant issues are identified and the Trust intends to take actions to improve the quality of the healthcare provided. Amongst these are the following responsive actions, selected as an illustration of the service-specific improvement work initiated via audit during the 2017/18 period.)

Royal College of Emergency Medicine Severe Sepsis 2016/17

Whilst the benchmarked findings for the timeliness of sepsis interventions placed the Trust above average overall, improvements are planned. These are linked to the overall intent to make interventions for sepsis available at the optimal time. Key actions include:

- Clear assignment of medical and nursing leaders for sepsis for every shift will ensure a continuous focus within the clinical team.
- Use of short 'bite-sized' teaching plus more in depth teaching as part of fuller team training days.
- Review of past cases to establish the cause of delay with interventions where this occurs.
- Trial of a sepsis trolley, replicating the same model as for resuscitation equipment.
- Rapid Assessment Triage: Patients who have been identified as having suspected severe sepsis, either by alerts from paramedics pre-arrival or at handover, will be seen by a senior doctor in order to initiate sepsis care pathways.

Royal College of Emergency Medicine Consultant Sign-off Audit 2016/17

Patients falling within certain high-risk groups attending the Emergency Department (ED) must be signed-off by a Consultant before discharge. The audit highlighted that this could be documented with greater reliability. It is assessed by the team that senior medical review and discussion takes place more frequently than the present documentation suggests. Key actions include developments to the electronic patient record to enable a prompt for sign-off to be displayed.

RCEM National Audit on Moderate and Acute Severe Asthma report 2016/17

Review of the findings by the ED team has led to development of new management standards for asthma in conjunction with the respiratory team. These are now incorporated into the ED suite of clinical procedures. Work is being undertaken to join-up services for unscheduled hospital attendances and ensure the care pathway is robustly defined. New inhalers are to be introduced as well as vital signs monitoring. These developments will be addressed as part of training programmes, using the resources available from Asthma UK.

Development of a safety checklist for asthma patients in emergency department bays will improve recording of abnormal vital signs and ensure completion of re-assessment within an hour. Asthma UK patient information is also to be adopted, providing clear information for patients on discharge.

National Inpatient Diabetes Audit (NADIA) 2016 report

The audit reports on the rate of patients being seen by a specialist diabetes team member, amongst other key elements of care. The Trust recently received NHS England funding for a two year project to improve inpatient diabetes care – enabling recruitment to an inpatient diabetes nurse post. This will support the improvements evident from the audit in the overall proportion of patients seen by the specialist team and will permit further training to be provided to ward teams.

British Thoracic Society Paediatric Pneumonia audit 2016

Changes in practice arising from the audit include restricting chest x-ray to use in severe or complicated pneumonia only. Likewise, blood testing should be reserved for the more severe cases. Oral antibiotics are to be used except if the case is severe or complicated. A departmental teaching session is in place to brief the junior medical team.

National Asthma Audit

The measures for a range of care processes have been incorporated into the respiratory team's action plan. These include:

- Educational sessions for the Acute Medical Unit team to address documentation requirements;
- Timely administration of steroids and other monitoring requirements will also be ensured by improved documentation;
- Implementation of a care bundle (a clear set of care processes) for asthma care.

National Fracture Liaison Service Database (part of the falls and fragility fracture audit programme)

Actions have focussed on the recruitment of an additional fracture liaison nurse to support assessment of patients according to best practice. The findings suggested that significant savings could be made through avoidance of hip fracture, spanning both acute health and social care services.

Sentinel Stroke National Audit Programme (Royal College of Physicians)

Aspects of the diagnosis and treatment of stroke such as screening, timely thrombolysis treatment (especially out of hours), swallowing assessment and direct admission to the hyper-acute stroke unit have been considered as part of the action plan, with actions focussing on training and education for relevant clinical teams.

National Audit of Inpatient Falls (Royal College of Physicians)

Actions have been formed to address ten priority issues leading from review of the findings; these include:

- To ensure timely assessment, promoting better use of the above-bed information boards, making the important information about the patient and falls risk clear to all.
- Review and implementation of the documentation supporting early identification of risks and early introduction of measures to reduce falls risk.
- Develop an education programme to support embedding practice for visual impairment assessment, access to appropriate walking aids and use of continence care plans.
- Improved joint-working with the dementia and delirium lead and linking to the actions addressing the national audit of dementia.

National audit of the management of psoriasis (British Association of Dermatologists)

The findings formed the basis to drive a standardisation in the recording of disease activity and patient wellbeing.

National Epistaxis Audit

This multi-centre audit assessed the various management options available in different trusts across the country and led to the Taunton ENT department using a new product in the management of epistaxis. A prospective audit will now be undertaken to assess the outcomes.

MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal Deaths from January to December 2015

The Trust's rate for perinatal death is lower than average, a fact that has been communicated widely amongst the maternity team as a celebration of success.

An aim arising from the report was to lower the number of women being admitted for induction of labour at 42 weeks (excluding maternal choice). The report found 5.3% were born post-term (42 weeks or greater), a higher percentage than the UK average of 2.5%. The % of women induced at or greater than 42 weeks has fallen since 2014 (7.3%). Actions include:

- Consultant review of working practices for booking women for induction and the timing of induction.
- Reporting to the maternity department's governance meeting, to oversee progress.
- Additional work is being undertaken to improve the recording of babies' ethnicity.

National Maternity and Perinatal Audit

Amongst a broad range of measures, this new audit report highlighted a need for review of Apgar scores at five minutes after birth; a concern being that the unit has a higher than average rate of babies scored as 7 (of 10) or below on the Apgar scale. This has been reviewed at Trust level and the maternity team have responded with action including:

- Completion of local audit, to understand the issues more fully
- Introduction of second-checker validation of Apgar scores
- Case review of records for babies with Apgar 7 or below at five minutes
- Monitoring of neonatal life support training completion.

RCR Audit of Prevention and Detection of Acute Kidney Injury in Adult Patients

This audit was undertaken to determine radiology departmental compliance with current UK guidance on contrast-induced acute kidney injury (CI-AKI). The department (and all departments nationally) are actioned to review their CI-AKI protocol and have established arrangements with the acute care physicians/renal team for the management of patients identified with CI-AKI.

Local clinical audit

The reports of 68 local clinical audits were reviewed by the provider in 2017/18 and Taunton and Somerset NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

The following are examples of projects conducted by clinical teams across the hospital and the changes proposed as a result of them:

Acute Medical Unit

Safe prescribing of IV fluids - This was an assessment of documentation to indicate whether practice was in line with NICE guidance (Clinical Guideline 174). The findings identified a need for improvement in the completion of the IV fluid chart by the junior medical team. Steps were taken to ensure adequate time is given to teaching IV fluids prescription during the doctor's induction and to emphasise completion of a 24 hour plan for fluids.

Cardiology

Inpatient Surgical Transfer times (re-audit) - The timely transfer of patients requiring heart surgery to other hospitals in the region is critical to ensure a good outcome and standards are set out within policy. Transfer should take place within seven working days. This round of auditing assessed the impact of the policy, introduced as a response to a prior audit. The policy has brought improvements, with over 80% of patient transfers meeting the 7-day target. For cases where transfer time was longer, there were justified clinical reasons for delays.

Endocrinology

Diabetic Ketoacidosis – An audit of admissions with diabetic ketoacidosis (DKA) in 2016, looking at patient characteristics and compliance with the Trust protocol for DKA management. The findings have formed the basis for review of the protocol, bringing it fully in line with national guidance recommendations.

Respiratory

Discharge documentation for patients admitted with acute exacerbation of COPD – This re-audit assessed practice in line with NICE Quality Standards further to implementation of a COPD discharge care bundle and modifications to the discharge care electronic record. Eight key standards were measured with findings highlighting constraints to effective delivery of the care bundle. A plan is proposed to involve a specialist respiratory nurse to more directly supervise and monitor the implementation of the discharge process.

Care of the elderly

Gentamicin administration and monitoring – Identified safety issues with dose calculations, the way the gentamicin levels were reported and monitored. Following the audit, the Trust prescribing guidelines were changed to a height-based dose calculation and the way the gentamicin levels were reported were revised.

Teriparatide in osteoporotic fracture prevention - the audit was carried out to assess compliance with NICE guidance (TA161) in preventing osteoporotic fractures and also to assess the use given the high cost of the medication. The audit confirmed about 90% compliance with the NICE TA161 and demonstrated that the exceptions were clinically justifiable.

Breast Care

Reporting of lobular carcinomas - A previous (2016) Breast Screening Programme Quality Assurance inspection had identified that the unit had a greater than expected number of lobular carcinomas diagnosed. Following the audit action points agreed included routine ordering of a specific test (E-cadherin) on any case thought to be lobular carcinoma and amending practice so that test-positive lobular carcinoma is double reported by two clinicians.

Critical Care

Tracheostomy Care - The Unit had introduced various changes to practice based on the NCEPOD publication addressing tracheostomy care, “On the right Trach”. The audit assessed compliance with the NCEPOD recommendations over the last year and overall confirmed good practice. In particular, compliance with consenting, checklists and documentation is good (significantly better than before the NCEPOD publication). The audit highlighted specific areas where practice could be improved, including minimising tracheostomy tube changes, ensuring a minimum of two senior intensivists are present, and checking with a bronchoscope on placement.

Surgical Admissions

Completion of Treatment Escalation Plans – These record the ‘ceiling of care’ decision for each patient, including the use of cardiopulmonary resuscitation. The Trust has in place a requirement for all inpatients to have a documented resuscitation status. Audit findings have led to actions to ensure the Treatment Escalation form is appropriately countersigned, to educate the surgical team and to improve the visibility of the form by locating it with the surgical clerking documentation.

Dermatology

Tele-dermatology audit – The audit is being used to assess provision of tele-dermatology support for acute inpatient care. Initial audit led to changes to allow consultants with responsibility for the patient being referred to tele-dermatology being included in the feedback. The audit is continuing to monitor this new model of service.

Skin cancer nurse-led follow up service – Has provided evidence that care is of a high standard and complies with NICE guidelines.

Urology

Audit of management and follow-up of non-muscle invasive bladder cancer - This was an assessment of compliance with NICE Guidelines (NG62). The findings led to actions linked to the patient record, improving the clarity of in terms of the size and number of lesions and the interval of follow-up checks. Development of a follow-up flow chart and improvements to pathology record-keeping were also addressed.

Ophthalmology

Management of macular oedema in Retinal Vein Occlusion - The findings have led to a wide-ranging set of service developments for consideration, including blood testing, review of risk factors, communication with the GP regarding treatment, defining a treatment pathway, ensuring early treatment, and use of laser treatment. The audit also linked to development of virtual clinics to help the department deliver the clinics needed to meet demand.

Trauma and Orthopaedics

Management of surgical chest drains in the trauma and orthopaedics department – The audit was undertaken to assess practice against local and national standards of care and to minimise radiation exposure**.** Although there was overall good compliance with guidelines, the use of chest x-ray was found to be high and there was some practice variation. Actions focussed on holding departmental chest drain insertion training sessions.

Ear, Nose and Throat Surgery

The use of antibiotics in post-tonsillectomy haemorrhage - Since the completion of this audit a protocol has been implemented for the management of post-tonsillectomy haemorrhage and patients are no longer being routinely prescribed antibiotics unless clinically indicated. This has reduced the unnecessary prescribing of antibiotics and its potential adverse side effects. A repeat audit has shown no significant changes in complication rates associated with tonsillectomy.

Paediatric post-tonsillectomy analgesia - The implementation of a standardised paediatric post-tonsillectomy pain relief has significantly reduced the re-admission rates of patients with post-tonsillectomy pain. This has therefore improved patient safety and post-operative experience and also reduces the number of bed stays for post-tonsillectomy complications.

Gynaecology

Consultant review of emergency gynaecology patients – The audit is supporting a business case for an additional gynaecology consultant within the service and the co-location of emergency gynaecology with other related services.

Use of methotrexate - There is clear guidance regarding the use of methotrexate in ectopic pregnancy and the audit provided assurance that guidance is followed and practice is robust.

The management of hyperemesis – The audit established that national guidance was not fully implemented for managing patients with hyperemesis. The guidance was highlighted to all staff and used as a basis for local guidance review.

Radiology

WHO safety check list use for surgical and interventional procedures – As a key part of the team's work to implement Local Safety Standards for Invasive Procedures (LocSSIPs) in radiology, the use of the Interventional Radiology WHO checklist has been monitored. This appears to be embedded in the processes for the large majority of cases. This applies primarily to the more significant interventional radiology procedures.

Oncology

Audit of electronic chemotherapy referral forms – the completion of forms was found to be reliable, whilst improvements can be made to the completion of all relevant detail. The quality of completion is being addressed via education.

Order of administration – multiple intravenous systemic anti-cancer therapy – Good practice is defined with the team's guideline for Prevention and Management of Chemotherapy Extravasation. A wide range of chemotherapy types received by 50 patients were assessed. All were found to be administrated in the correct order, therefore the only action was to monitor that this is sustained.

Dietetics

Audit of nasogastric tube insertion documentation and nasogastric tube nursing competency assessments - Initial audit has helped with the refinement of the tube insertion documentation. It has also informed what needs to be communicated to staff about the documentation requirements of a National Patient Safety Agency alert on this topic.

Physiotherapy

Physiotherapy record-keeping audit - The audit will help identify areas requiring a change in documentation and also allow the implementation of training needs for therapists to ensure that nationally defined standards are maintained.

Therapies Falls Audit - One area that has greatly improved is the documentation of patients being involved in the development of their treatment planning. This demonstrates that as clinicians we are considering/identifying patient-centred goals and therefore making their rehabilitation more functional to the individual. Physiotherapists and occupational therapists have also been educating ward staff to highlight patients to therapies in the event of an inpatient fall.

Trust-Wide Audits

Audit and patient experience survey of Consent - This rolling programme assesses the documentation and processes relating to consent for surgical and other types of invasive procedures, in line with Trust policy. The survey component provides the patient perspective on the conduct of the process of consent, focussing on the quality of information provided and opportunities for discussion of the risks, options and likely outcomes. Overall, practice was shown to be good, in line with the key policy requirements. An area for development is the low numbers of patients receiving a copy of the consent form; addressed via feedback to all relevant teams.

Food and drink availability at ward level - The availability of food and drink for inpatients is a fundamental of care which is reviewed annually via this audit, drawing on national guidance and underpinned by the Health and Social Care Act Regulations. Overall, good availability was evident, with improvements required to ensure low sugar options are consistently on offer. The recommended core items to be available on all wards have been highlighted to ward mangers. Procurement arrangements have been reviewed.

Enteral feeding systems and administration of oral liquid medicines – This audit, led by the medicines management nurse, assessed practice in over 50 clinical locations across the Trust against National Patient Safety Agency (NPSA) recommendations (Alert 19). Findings were used as a basis for awareness-raising, developments to training content and improvements in use of effective methods for dose measurement.

Safety of Peripheral Venous Cannulas – An audit assessing the success of a newly introduced cannula chart in ensuring guideline compliance. The findings demonstrated that the chart helped ensure good practice and guideline implementation.

CLINICAL RESEARCH

Four key documents have been published in the last 12 months that reinforce the Government's ambitions for research both to grow and be completely embedded in NHS services these are:

- NHS England Research Plan *(4 April 2017);*
- The Life Sciences Industrial Plan *(30 August 2017);*
- Twelve actions to support and apply research in the NHS *(NHS England & National Institute for Health Research, November 2017;*
- Government's Industrial Strategy *(27 November 2017)*.

The overarching theme of all of these developments is an increase in collaborative working at all levels; encouraging collaboration between agencies in the wider health community, trusts, academia and industry. Key points that are beneficial to the Trust are:

- that NHS England has a legal duty to promote research and the use of research evidence in the NHS.
- the Government's Life Sciences Industrial Plan aims to support a 50% increase in the number of clinical trials being run in the UK in the next five years.
- the Industrial Strategy Sector Deal will help ensure new pioneering treatments and medical technologies are produced in the UK, improving patient lives and driving economic growth. The deal involves substantial investment from private and charitable sectors and significant commitments in research and development from the government.
- that to deliver this agenda, the National Institute for Health Research (NIHR) and NHS England are jointly driving system-wide changes to speed up the process of conducting research, disseminating and adopting the results of research for the benefit to the NHS and its patients, whilst capitalising on fiscal savings to support long-term sustainability.

All of this is done so that the NHS supports and harnesses the best research and innovations in medicines, devices, diagnostics, and digital products. The overall aim is to improve patient outcomes, transform services, ensure value for money and grow the UK economy; and to do so in a way that helps ensure a sustainable NHS for tax payers.

Commercial collaborations

The Trust's first commercial research collaboration led by a Trust chief investigator – Dr Fred Mayall, is recruiting well with 78% of participants recruited.

The Trust has already signed up to an agreement with TrinetX, a commercial data warehouse to provide anonymised data to research partners, so that patients with

rarer conditions that are eligible for trials may be identified more readily and researchers don't waste resources setting up trials in locations without the relevant patient population .

The Trust has also been invited to join a prime site collaboration with IQVIA, which will mean that the Trust will be in a position to influence commercial trial development at an early stage to enhance the deliverability of the research within the NHS and will also be able to join new trials sooner.

Academic grants

The Trust has been notified of a successful application for a 'Research for Patient Benefit Grant' awarded to Dr Justin Pepperell to collaborate with the University of Oxford to develop his trial for patients with mild to moderate sleep apnoea.

Mr Nick Burns-Cox, a consultant urologist at the Trust, has been invited to collaborate with the Karolinska Institute in Sweden to develop research to help develop a more accurate diagnostic test for men at risk of developing prostate cancer. The Trust has agreed to sponsor the research and the project is currently in development.

Professor Rob Andrews' trial, EXTOD education, has recruited well and developments for a second phase with a larger grant are underway.

The Trust has continued to work with its local health community partners in Yeovil District Hospital NHS Foundation Trust and Somerset Partnership NHS Foundation Trust to develop the Somerset Research Collaborative; now supporting an active and highly successful portfolio of studies across organisational boundaries and a range of clinical specialities.

Further collaboration with Royal Devon and Exeter NHS Foundation Trust in respiratory research is also planned for the future.

The impact of this to the Trust is that the Department of Clinical Research continues to increase the number of patients recruited to research and also the number of specialities that offer research as a treatment option. Health systems and the delivery of services is also a subject for research to ensure that innovation, transformation and the provision of services is evidence based.

In 2017/18, the Trust was allocated £1,004,440 to support research staffing and infrastructure via the NIHR Clinical Research Network: South West Peninsula, with a further £34,310.71 directly from the Department of Health and Social Care. Revenue from the conduct of research of £431,719.66 has been invoiced for, as at 9th April 2018.

The department projected total recruitment of 1,360 participants at the start of the financial year for the National Institute for Health Research Portfolio of studies.

The number of patients receiving relevant health services provided or sub-contracted by Taunton & Somerset NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1900. This recruitment figure relates to 111 active studies. Trust employees have demonstrated the vibrancy and innovative practice of a research active organisation in the last twelve months by producing an extremely high volume of successes, conference abstracts and publications in high quality academic journals. Dr Emma Wesley, a new Trust principal investigator has begun developing the portfolio of research in gastroenterology, achieving the first two global participants recruited at the Trust in her first commercial clinical trial.

Ninety four articles and abstracts were produced. The topics were wide ranging across specialities and also across the whole range of professions. Analysis of data provided by the Library Service demonstrates that the most prolific specialities for successful publications are bariatric medicine and respiratory medicine.

Speciality	**Number of publications**
Bariatrics	14
Respiratory	7
Obstetrics and Gynaecology	6
Emergency Medicine	6
Surgery	6
Orthopaedics	6
Cardiology	6
Paediatrics	4
Management	4
Gynaecology Oncology	4
Oncology	5
Maxillofacial and Dental	4
General Medicine	3
Rheumatology	3
Mental Health	2
Diabetes	2
Anaesthetics	2
Urology	2
Radiotherapy	2
Ophthalmology	1
Vascular	1
Primary Care	1
Biochemistry	1
Neurology	1

Haematology	1
Total	**94**

The Trust continues to host the coordinating centre of the NIHR Research Design Service – South West.

COMMISSIONING FOR QUALITY AND INNOVATION FRAME-WORK (CQUIN)

2.5% (c. £5 million) of Taunton and Somerset NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Taunton and Somerset 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. 2.5% of income for 2016/17 was also conditional on achieving quality and innovation goals.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at **http://www.musgroveparkhospital.nhs.uk/about-your-hospital/our-quality-improvement-priorities-and-cquins/**

CARE QUALITY COMMISSION (CQC)

Taunton and Somerset NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission carried out an inspection of the Trust between the 30th August and 28th September 2017, with unannounced inspections of four core services and a review of the well-led key question at trust-level. The Trust continues to be rated as "Good" overall, with a number of recommendations to further improve care. Please see the Chief Executive Officer's comments in the Foreword on page 1.

Taunton and Somerset NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Care Quality Commission has not taken enforcement action against Taunton and Somerset NHS Foundation Trust during 2017/18.

INFORMATION ON QUALITY OF DATA

The Trust agreed a new Data Quality Strategy with three clear aims:

- Creating the right culture
- Timely Resolution of Data Quality Issues

- Maintaining high Quality Data

Work is underway to deliver the strategy's aims with a revised governance structure, the development of a supporting data quality policy and the production of a dashboard to give visibility of data quality issues and the progress made in their reduction.

In the absence of Spine connectivity improvements the quality of core demographic data has been made through the use of technologies within the Trust's interface engine. In particular, the completion of NHS number as a unique identifier. There are plans to explore further potential developments in this area.

Taunton and Somerset NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in published data with valid NHS numbers and GP practitioner code were as follows:

Indicator	**Accident and Emergency care**	**Admitted Patient Care**	**Outpatient Care**
Number of records which included the patient's valid NHS Number			
% of valid NHS Numbers received from EPR	95.7	99.4	99.7
% of valid NHS Numbers sent to SUS	98.4	99.8	99.9
Number of records which included the patient's valid General Medical Practice Code			
% of valid GP Practice Codes received from EPR	99.5	99.9	99.8
% of valid GP Practice Codes sent to SUS	99.7	100	100

There has been an improvement across the board in the completeness of data submitted to SUS with a high correlation in most areas between the data contained within the core Electronic Patient Record (EPR). In particular the percentage of valid NHS numbers submitted to SUS through the work on the Interface Engine has increased by 4% for Emergency Department attendances this year.

Taunton and Somerset NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Taunton and Somerset NHS Trust will be taking the following actions to improve data quality:

- Extending the use of Spine Mini Services through the Trusts Integration engine to improve completeness of data.

- Extending current data quality dashboard reporting on data quality issues.
- Working with Electronic Patient Record Supplier to make system improvements such as standardised format and mandatory fields
- Implementing new data quality policy
- Identifying and training data quality champions throughout the Trust.

INFORMATION GOVERNANCE

Taunton and Somerset NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/18 was 71%, and was graded green with a rating of satisfactory.

CLINICAL CODING ERROR RATE

The Clinical Coding Audit, for information governance purposes, was performed internally on a sample of 200 records across all specialties.

The results for the clinical coding audit showed good overall figures. The diagnoses coding, with both the primary diagnosis (90.95%) and the secondary diagnosis (88.34%), are exceeding the 90% and 80% respective recommendations given for the Information Governance Toolkit (IGT) Requirement 505 attainment level 2. The procedure coding also exceeded the recommended target, with the primary procedure correct at 94.85% and the secondary procedures at 90.20%.

	Percentage achieved	**IGT 505 level 2 target**
Primary Diagnosis	90.95%	90.0%
Secondary Diagnosis	88.34%	80.0%
Primary Procedure	94.85%	90.0%
Secondary Procedure	90.20%	80.0%

Recommendations

All of the following recommendations from the 2016/17 IG 505 audit have been reviewed and have either been actioned or are in the process of being actioned:

The clinical coding managers are to remind the coders of the importance of coding all conditions which affect the care of the patient.

- This recommendation was actioned immediately by the clinical coding managers.

The clinical coding managers are to remind the coders to check all systems and documentation when coding in order to code capture all appropriate radiology activity and to provide clarification to the coders regarding how to interpret the plan to admit and the coding of radiology scans.

- This recommendation was actioned immediately by the clinical coding managers.

The clinical coding managers are to re-audit the coders with the overall lowest depth of coding to ensure that the learning from this audit has been effective, and if there has been no improvement to provide action plans for these coders.

- This audit and possible action plans to be undertaken within the financial year of 2017/18 by the clinical coding managers. The audits are now underway with effect from January 2018 and action plans will be written if required.

The clinical coding managers are to remind the coders that the primary diagnosis rule applies to individual episodes within multiple finished consultant episode spells.

- This recommendation was actioned immediately by the clinical coding managers.

The clinical coding managers are to remind the coders of the national standards regarding the coding of oncology conditions.

- This recommendation was actioned immediately by the clinical coding managers.

The clinical coding managers are to continue to provide support to coders coding complex cases.

- This is an ongoing commitment by the clinical coding managers.

In addition to the yearly IG 505 audit the coding managers undertake validation of coded data on a monthly basis. About 400 episodes are checked and any coding corrections needed are made within the same calendar month.

LEARNING FROM DEATHS

1. The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

During April 2017 to March 2018, 1,342 patients at Taunton and Somerset NHS Foundation Trust died (including inpatients and patients in ED). This comprised the following number of deaths which occurred in each quarter of that reporting period:

Quarter	Number of Deaths
Quarter 1: April – June 2017	293
Quarter 2: July – September 2017	272
Quarter 3: October – December 2017	331
Quarter 4: January – March 2018	446

Note – These include deaths of patients whilst an inpatient or in the Emergency Department only.

2. The number of deaths included in section 1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

By 6th April 2018, 640 case record reviews and four investigations have been carried out in relation to 585 of the deaths included above.

In two cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record or an investigation was carried out was:

Quarter	Number of Deaths
Quarter 1: April – June 2017	191
Quarter 2: July – September 2017	197
Quarter 3: October – December 2017	143
Quarter 4: January – March 2018	54

A single death may be reviewed by more than one clinical team. There is often a delay between the death occurring, the case reviewed and reported to the mortality surveillance group, hence the total of reviews conducted toward the end of the reporting period will not be the final total.

3. An estimate of the number of deaths during the reporting period included in section 2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

19, representing 3.3% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter this consisted of:

Quarter	Number of Deaths
Quarter 1: April – June 2017	9 (4.7%)
Quarter 2: July – September 2017	7 (3.6%)
Quarter 3: October – December 2017	3 (2.1%)
Quarter 4: January – March 2018	0 (0.0%)

These numbers have been estimated using a locally designed tool to assess quality of care developed in line with the principles of Structure Judgement Review Methodology as the method or review advocated nationally.

The reviewer records the key aspects of care for which concerns are judged to have occurred and rates the quality of care at Taunton and Somerset NHS Foundation Trust using the below scale:

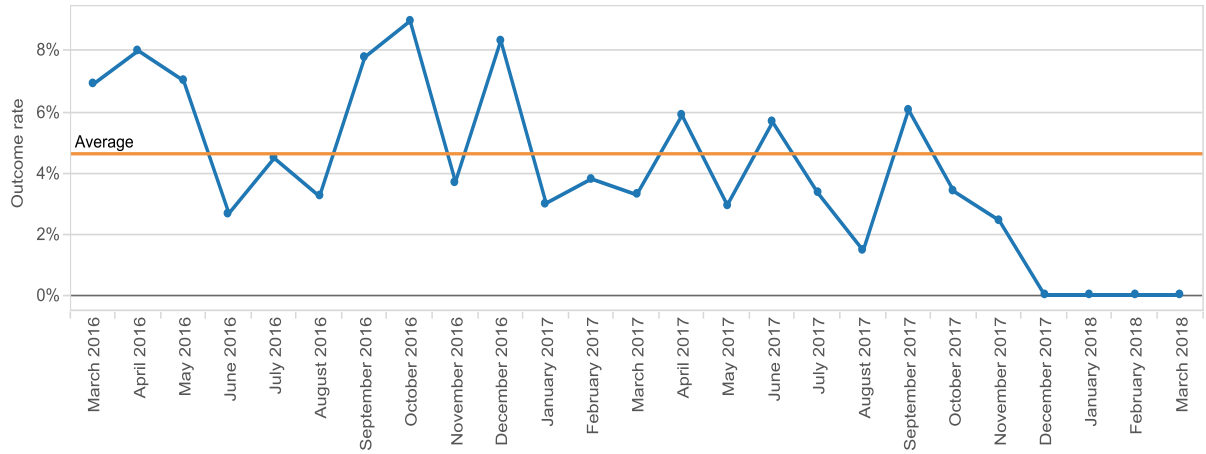
A. No significant care issues identified and care considered to be excellent despite the outcome
B. No significant care issues identified
C. Some care issues identified but not related to death
D. Care issues identified which may have contributed to death
E. Serious issues identified (failure to follow procedures/ unacceptable standards of care).

Deaths with at least one review with a score of D or E are included in the percentage above.

4. A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in section 3.

The numbers of mortality case note reviews that have demonstrated significant care concerns that may have been related to death have been low. The mortality steering group use this information (in run chart format) to track the number of care concerns on a monthly basis. This gives the Mortality Steering Group (MSG) oversight into significant changes within ‘care concerns’ throughout the Trust over time. This information can be used to further investigate potential changes related to global deterioration (or indeed improvement) in care for mortality cases. At the present time the run chart (see below) has shown no significant variation from the Trust average.

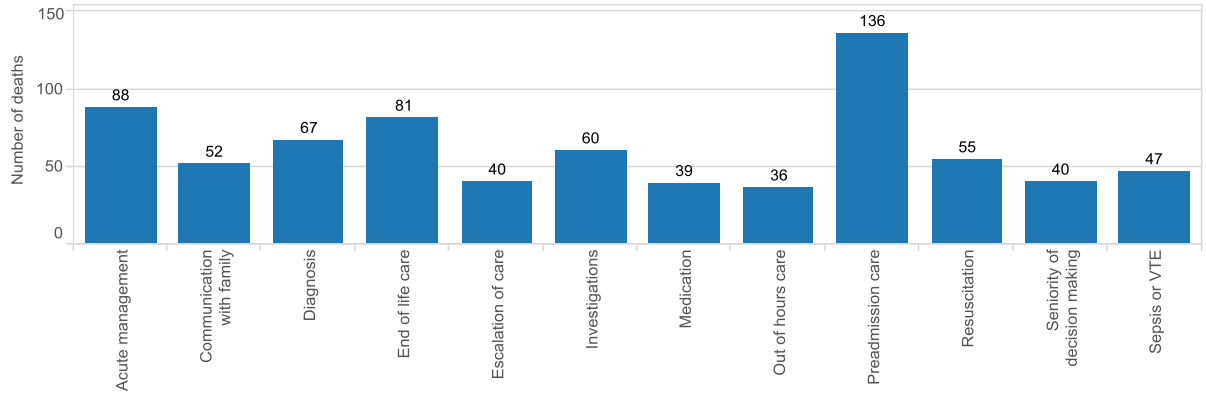
Percentage of mortality review cases assessed as either possibly avoidable, avoidable or having care issues contributing to death or serious care issues



The Trust has (and continues to) refine the process around learning from cases where there is thought to be a care concern contributing to death. In cases where there are serious care issues identified (E on care scale – see section 3) the mortality review case is automatically referred through to the Serious Incident Review Group (SIRG) and, as appropriate, and Serious Incident investigation is undertaken. In mortality cases where there are significant care concerns, but the impact on the contribution to death is not known (D/C on care scale) then these cases are referred back to the local directorates for review. The Trust is currently working on the governance of these cases and ensuring the learning process through directorates is robust.

The mortality case review process is used to identify any potential causes for sub-excellent care at any stage in the patient's final admission. This is performed for all mortality cases; regardless of whether there have deemed to be care concerns contributing towards death. This breakdown of issues helps with thematic analysis and is provided to the improvement team to help guide focus for further improvement work. A summary of these themes is displayed below:

Area of care concern *Based on the presence of a concern in any review for each death*



The MSG has recently reviewed data (collected by the MSG's clinical quality and patient safety analyst) on pre-admission care concerns identified using the above

methodology. During this analysis missed opportunities for advanced care planning and inappropriate admissions to acute care were the overarching themes identified.

5. A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see section 4).

The Trust actively promotes the use of Mortality and Morbidity meetings to begin the learning process when discussing mortality review cases. These are a combination of single speciality (eg Respiratory), multidisciplinary (eg Cardiology) and multi-speciality (eg General surgery) meetings and are part of the consultant core supporting professional activities. They are well attended by the consultant body and the junior medical teams, and cases are discussed with appropriate learning for clinical teams distributed at this time.

Specific examples included teaching on end of life care within general surgery/vascular patients and involvement of the learning disabilities team within respiratory medicine. Cases that have been identified through the mortality process that have been referred through to the serious incident review group, involve cases in which sepsis care (in ED) were inadequate and care concerns regarding the end of life care (in an unavoidable death). The information from these cases has tied into ongoing work in the Trust around these themes.

The mortality case review process has allowed the MSG to accumulate data regarding mortality within the Trust. The MSG reviews this data on a monthly basis and disseminates learning/themes around mortality via a network of directorate mortality (clinical) leads. The mortality review process has taken time to become established and the first stage (to mid-2017/18) has focused on identification and mortality process. The MSG had identified issues regarding the co-morbidity and palliative care coding of final acute hospital episodes and have worked with the coding department to see an improved reporting of both of these.

The work described above regarding pre-admission concerns identified through the thematic analysis, will be used to shape work via the collaborative improvement board and with the end of life team.

6. An assessment of the impact of the actions described in section 5 which were taken by the provider during the reporting period.

Considerable input has been made by the Trust in establishing the process for morality reviews. This has been a significant undertaking by the clinicians performing the reviews and the governance infrastructure needed to support this. The MSG is still in its relative infancy. It is very difficult to assess impact resulting directly from mortality reviews at this stage due to a number of different factors;

the process (with respect to learning) is still in development, there is a considerable overlap with emerging themes to work already being undertaken within the trust (eg end of life, palliative care) as well the difficulty in tying in local (directorate) governance and learning with |Trust-wide processes.

With respect to work within the MSG, the change of approach, listed above, with respect to co-morbidity and palliative care coding has been successful with an increase in both. The increase in comorbidity coding has brought the Trust up to the national average SHMI comorbidity per spell and above the national average HSMR comorbid per spell, and although palliative care coding per discharge is still below the national average (1.2% compared to around 2.2%) there has been significant improvement towards this figure.

7. The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in section 2 in the relevant document for that previous reporting period.

We have not consistently recorded the date reviews are completed. We acknowledge that there is often a delay in the death occurring and the review being notified centrally. Therefore, for section 7 and section 8 we have provided figures relating to all reviews conducted for deaths occurring during the fourth quarter of 2016/17, regardless of when these were notified. This approach assumes that all review for Q4 deaths were conducted within the2017/18 period.

As an estimate, 263 case record reviews and 0 investigations completed after 1st April 2017 which related to deaths which took place before the start of the reporting period

8. An estimate of the number of deaths included in section 7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

8 representing 3.3% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in care provided to the patient. This number has been estimated using the locally designed tool and methodology described above.

9. A revised estimate of the number of deaths during the previous reporting period stated in section 3 of the relevant document for that previous reporting period, taking account of the deaths referred to in section 8.

43 representing 5.0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

PART THREE - OTHER INFORMATION

Part Three of the Quality Account provides an overview of the Trust's achievements and progress within quality indicators that have been selected by the board in consultation with stakeholders, including CQUINs. The data reviewed covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. This demonstrates that the Trust has provided high quality of care, but with room for further improvement as highlighted below. Many of the indicators are the same as for previous years, with a small change to the infection control indicators within the patient safety area to include additional indicators that focus on the outcome for patients alongside process indicators relating to hand-washing and managing norovirus.
In addition, Part Three also includes further information on a number of key work-streams that the Trust is currently focussing on to improve quality and a review of performance against national targets and regulatory requirements.

PATIENT SAFETY

Hand washing

A key component in the reduction of infection is thorough hand hygiene by all clinical staff. This is an important issue for the Trust and all our patients.

Monthly hand hygiene compliance audits are carried out in all areas. The infection prevention and control team also undertake hand hygiene validation audits to check the reliability of the data collected and identify areas for improvement. Results are fed back to directorate managers, senior nurses and the ward sisters and teams.

Local Target: 90% compliance
Actual 2017/18 – 94%

Norovirus

Norovirus is one of the most common causes of infective gastroenteritis in the UK. It is highly infectious and causes regular outbreaks of diarrhoea in the community and hospitals. Norovirus outbreaks can occur at any time of the year, but are more common in the winter months, with hospital outbreaks often leading to ward closure and disruption in hospital activity.

In 2017/18 there were 23 confirmed norovirus outbreaks in the Trust, resulting in restrictions being put in place on wards. Outbreaks were managed in line with the Trust's 'Management of Norovirus' policy and the *Guidelines for the management*

of norovirus outbreaks in acute and community and social care settings' (DH Norovirus Working Party December 2011).

Sustaining reductions in healthcare associated infections

Methicillin resistant staphylococcus aureus (MRSA) bloodstream infections

Methicillin resistant staphylococcus aureus is an organism which is resistant to the antibiotics usually used to treat infections caused by the staphylococcus aureus bacterium. Infections caused by the bacterium can range from mild to life threatening and can be particularly hard to treat as special antibiotics have to be used. The Trust's aim for 2017/18 was to have no MRSA Trust-apportioned bloodstream infections (specimen taken on or after the third day of admission in line with the standard national definition), as agreed with the Trust's commissioners.

Unfortunately, the Trust had three cases of MRSA bloodstream infections in 2017/18. Multi-disciplinary reviews were completed to identify the source of the infection and any areas of sub-optimal practice that may have contributed to the case. Opportunities to improve a) MRSA screening and b) checking patient histories for any previous history of MRSA were identified and this learning was shared and improvement actions put in place.

Clostridium *difficile* Infection (CDI)

Clostridium *difficile* is a bacterium that is present in the gut of up to 3% of healthy adults and does not normally cause any harm. CDI can occur when the normal bacteria in the gut are disturbed, usually by taking antibiotics. This allows the bacterium to multiply rapidly in the gut and produce toxins which cause diarrhoea, and in some cases severe inflammation of the bowel.

The Trust continues to implement a number of actions to help reduce the risk to patients, which includes:

- Robust antibiotic stewardship to help reduce the unnecessary use of antibiotics;
- Prompt Isolation of patients with diarrhoea and / or a confirmed CDI;
- Isolation of patients with a history CDI, if they are at an increased risk of developing symptoms;
- Scrupulous hand washing with soap and water following contact with patients with CDI;
- Regular review of patients with CDI by a microbiologist and the Infection;
- Prevention and control team to support medical management and isolation practice;

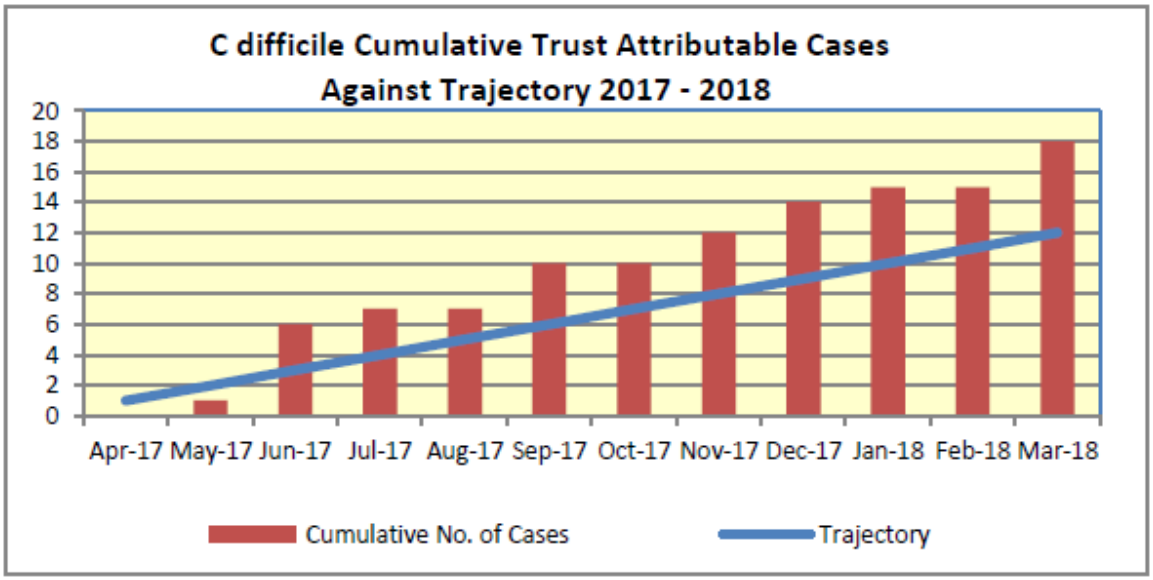
- Enhanced cleaning of rooms with hydrogen peroxide based technology to help eradicate CDI spores;
- Enhanced cleaning of equipment with a sporicidal agent;
- Working closely with the Trust's partners in the community to help reduce the risk of CDI in primary care.

In 2017/18, the Trust had a total of 18 trust-attributed cases (defined as specimen with a positive toxin test result taken on or after the fourth day of admission). This was a sharp increase from the previous year when there were only eight cases identified. However, this had coincided with a general increase in CDI cases in Somerset this year compared to last year, and this may have impacted on the number of hospital cases.
All cases of Trust-apportioned CDI are thoroughly investigated to assess whether there was any lapse in care that may have contributed to the case. These assessments are subsequently peer reviewed and validated with the Trust's commissioners. To date, in five of the 18 cases a lapse of care that could have contributed towards the case was identified. Learning included ensuring appropriate antimicrobial prescribing and compliance with hand hygiene, and learning was shared with the appropriate clinical staff and improvement actions taken.

A high standard of environmental cleaning is a key infection control measure for CDI. A new centrally managed cleaning arrangement was introduced in the Trust in November 2017, which will help ensure a high standard of cleaning in all areas of the hospital and ensure that any gaps in the cleaning service are readily covered in high risk areas.

To ensure the optimal use of antibiotics, antimicrobial stewardship remains a high priority in the trust, with regular review of broad spectrum antimicrobial prescribing on both medical and surgical wards by a consultant microbiologist and antimicrobial pharmacist.

The use of high risk broad-spectrum antibiotic prescribing has significantly reduced in favour of lower risk combination therapy with narrow spectrums agents, and the Trust remains amongst the lowest users of these agents in the region.



PATIENT EXPERIENCE

DIETETICS - ENSURING PATIENTS RECEIVE ADEQUATE AND NOURISHING FOOD

Nourishment is a key element in recovery from illness or surgery and maintenance of good health. Food and nutrition is a priority for high quality care and the Trust knows that it needs to maintain the programme for continual improvement of food services, food availability, staff education and practice. The Trust provides patients with a range of nourishing foods, as needed, and aims to ensure that they are given the assistance as required.

Food availability

Availability of food, including hot meals and snacks, 24 hours a day enables patients to have flexible access to nutrition in order to meet their needs. In addition to the wide menu of both hot and cold food served at the usual mealtimes, the Trust has the facilities required to provide hot meals ‘out of hours’ for patients who are unable to eat at the usual mealtimes or would prefer a hot meal at a different time, whether this is day or night. To provide this flexibility, the Trust has microwaves on every ward and freezers which are stocked with balanced nutritious meals. These meals can cater for a range of diets, including gluten free, vegetarian, modified textures, milk free etc.

An iPad system for food ordering is in use. This has a number of benefits, including a safer system for ordering special diets and immediate electronic delivery of patient meal choices from wards to the kitchen. The iPad has been

further refined with the addition of nutritional information for each menu item. The aim is also to add pictorial menus so that this is available at the patient's bedside over the course of the next financial year.

Staff knowledge

Staff education on nutrition and food provision continues to be a priority with the requirement that a minimum of 80% of the ward staff have the knowledge they need about food availability in order that patients receive what they need. A ward food folder, detailing information on food provision and special diets is available on each ward. This is supplemented by menus and special diet information available on the ward iPads and is for use by both staff and patients to ensure that patients are able to receive the food they need and would like.

With the change in December 2017 of staff roles and responsibilities for patient food ordering and service, the priority has been to provide Food Safety Awareness and Food Hygiene training for relevant staff. A continuing programme of course dates is enabling the key staff to receive this important training.

Help with eating

The aim for patients receiving sufficient food within or outside mealtimes focused on ensuring those who needed assistance with eating reported that they had been helped. The Trust aims for 95% (good) achievement for this. The target was set in the context of improving assistance to patients, between and at mealtimes, by:

- ensuring they could reach their food and drinks
- opening packaging
- offering finger foods
- providing prompting, or
- fully helping them to eat where this was needed.

With the Trust-wide change from the inpatient survey to the 'Two minutes of your time' survey, the patient feedback for 'Help with Eating' changed to a separate, bespoke survey in 2017/18. Three surveys have taken place since June 2017 covering 18 wards. In June 2017, 94.7% of the patients reported receiving the help they needed. In September 2017, the figure was 66% however this improved to 86.6% in February 2018. The Trust continues to compare well from the 2016 National Inpatient Survey with the question patients are asked, 'Did you get enough help from staff to eat your meals?' The results when benchmarked show that the Trust is similar compared to other trusts on this question.

National Recognition for Improvements in Catering

The Trust received positive publicity in January 2018 when it was named as the second best hospital in England for its healthy food and drink by the Health

Business magazine. It follows many improvements made by the Trust over the last few years.

Improvements achieved in the last year

- Introduction of new attractive blue crockery on all adult wards. This has been undertaken as there is evidence that suggests coloured crockery aids food intake in the elderly, particularly people with Dementia, by helping them to distinguish the food on the plate.

- In December 2017, the hospital undertook the Droplet® trial with the aim of promoting and improving patient's hydration. This is a dementia-friendly mug and plastic tumbler that plays a series of pre-set messages to patients if they are not drinking regularly enough. Following the successful trial, where those patients using the Droplet® drank 63% more than those who didn't, the plan is to introduce the mugs and tumblers across the hospital by May 2018.

- Special new menus have been developed and introduced on the Children's wards in September 2017. These include a wide range of popular choices along with healthier dishes, containing less salt and sugar. The change of menus has been accompanied by a Ward Food Folder designed specifically for the Children's wards.

- Introduction of 'Bags of Kindness' for those patients who are being discharged home with no one to organise food supplies in their houses in preparation of their arrival. These food bags provide basic provisions to tide the patients over until they are able to get groceries in to their homes.

- An audit of food and drink availability on drinks rounds and food stocked in ward freezers was undertaken in May 2017. This showed good compliance against the expected standard, with the exception of three of the 33 items checked, where stocks were inconsistent. Recommendations for improved availability of these have been made to the relevant ward managers.

- New and improved nursing care plans have been introduced for patients at risk of malnutrition.

- Close working with all food and drink outlets on site to make sure we continue to promote healthy nutritional choices, including strongly encouraging the sale of non-sugary drinks and not allowing advertisements and promotion of sugary drinks.

- Once again the Trust has actively participated in the international Nutrition and Hydration week, held in March 2018. This year, activities in the main hospital concourse focused on trialling new dishes which will be introduced in the updated patient menus being developed and also on promotion of

hydration through demonstration of the Droplet® mugs. In addition, cakes were supplied to the wards for the 'Big Tea Party' and there were special event days run by ward staff on their wards. Over the course of 2017/18 some wards have shown excellent initiative in running other special events including a Jubilee Garden Party, and Harvest and Easter themed days, which all help to promote the importance of nutrition for patient health and wellbeing.

- The Trust continues to have a group of highly committed 'Nutrition Champions'. These are ward staff who work to improve nutrition in their ward areas with support from the Dietitians and Dietetic Assistants.
- Work continues to ensure that the Trust meets the requirements of national patient safety alerts and an international improvement programme for patients requiring tube feeding.

Further improvement identified

- Menus are being updated and will include a choice of hot finger foods and special small, but energy dense, meals to support patients on our Care of Older People wards. Also, to support those patients for whom healthier (lower fat and sugar) food choices are appropriate during their hospital stay, menus will also include a wider range of options.
- Modified texture menus and support materials will be revised, in preparation for new coding of food and drink for patients with swallowing difficulties (dysphagia) being implemented by April 2019.
- Work with ward teams to ensure that food services and mealtime systems continue to improve to meet our patients' needs. This will include a programme called 'Mealtimes Matter', which will be introduced to ensure that focus on mealtimes is maintained, particularly ensuring that all patients needing help with eating always receive it.
- The Dietitians will be working with their colleagues in Somerset Partnership NHS Foundation Trust to develop new nutritional care plans for patients on discharge, so that there is clearer communication to support patients to be in control of their own care wherever appropriate.
- Further auditing of compliance and accuracy of nutritional screening with a plan for regular education and training for ward staff, including an e-learning programme.
- Further work will be undertaken in collaboration with our on-site food and drink outlets to ensure that healthier choices are available ahead of the national recommendations.

SEEKING AND LEARNING FROM FEEDBACK

With an ambition to provide high quality patient and family centred care, it is fundamental in planning and delivering services to gather people's views and experiences and act upon these to shape and improve the service and culture.

As part of this it is vitally important to seek out and actively engage with a diverse group of people who have experience of the services delivered by Taunton and Somerset NHS Foundation Trust.

In 2017 the following feedback was gathered:

***CQC inspection 2017*:** Overall rating: Good. Well-led rating: Good.

'The Trust had engagement with the public, its staff, people who used services, and stakeholders, in order to take their views into account when planning services'.

'Engagement with the patients and public was important to staff who acted on complaints or incidents to improve care'.

For urgent and emergency services it noted*: 'The unit valued feedback from patients'.*

For Surgery it was recognised that *'there were positive Friends and Family test results'.*

***NHS Choices for 2015/16*: NHS Choices for October 2016 – December 2017: Overall rating 3 out of 5 stars** (based on 11 ratings).

The Trust has continued its subscription to Care Opinion. There are responders trained and in place at a local level allowing local responses and thus visibility and actions to stories posted.

Summary of activity between 1 April 2017 and 6 April 2018 for Taunton and Somerset NHS Foundation Trust (TST) and Warwick House Medical Centre

179 stories (173:TST, 6: Warwick House) were shared and viewed 19,731 times. The three most popular stories were:

I could hardly speak to express clearly my gratitude
Posted by Street as the patient eight months ago

'I had to attend A&E with a sudden onset groin pain and swelling.

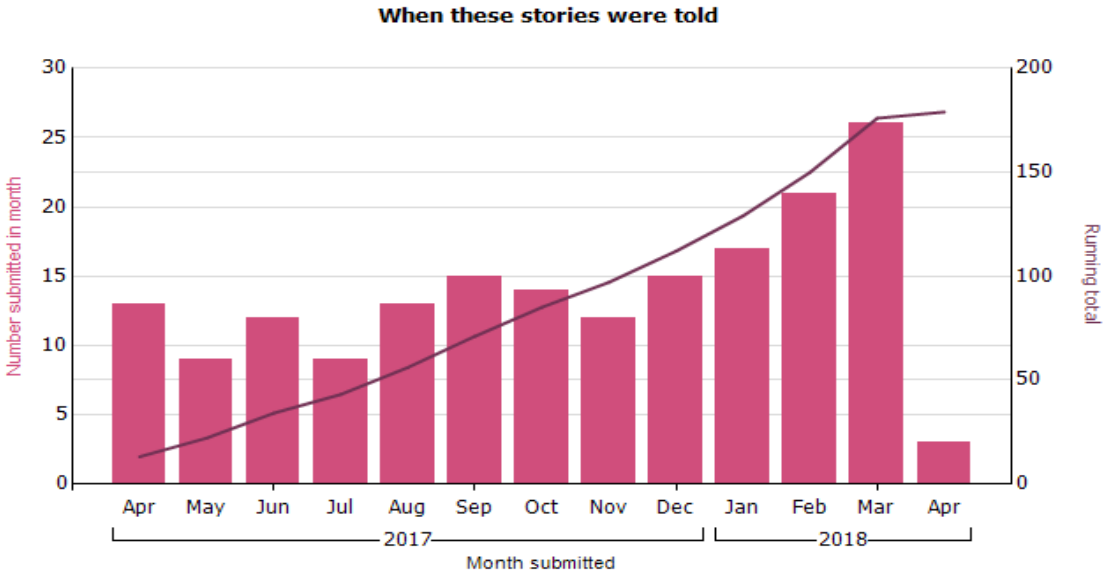
A&E looked busy. The A&E receptionist acknowledged my discomfort and organised immediate triage. After an examination I was taken to a cubicle where I received swift attention to have pain alleviation and a diagnosis of potential strangulated femoral hernia. The staff nurse, HCA and doctor made me feel safe and in good hands.'

My father's care
Posted by AJSWSM as a relative three months ago

'My father was admitted into A&E in December 2017. The care he received was absolutely first class. He was treated quickly, professionally with care and kindness. As a family we were kept informed and also treated professionally and with kindness from all members of staff. He was later admitted onto Sheppard Ward where all the staff were wonderfully caring.
This was our first experience of Musgrove and we can honestly say we were very impressed.'

Sepsis… and a sneaky extra appendix hit
Posted by MissusHobbit as the patient last month

'I was taken in displaying all the signs of sepsis… I can honestly say I have never been so terrified or so ill at any point in my life and from the moment I came into A&E I knew I was being care of. [*sic*]
A truly phenomenal team (special thanks to Hannah, Kat and Dr Tom) who had me assessed and up onto Montacute Ward under quite honestly the most amazing people I have ever known so quickly.' [*sic*]



Most common tags added by authors to these stories (any reported by more than 1 author)

What's good?	
staff	44
Care	30
treatment	10
communication	8
compassion	8
friendly	7
nurses	7
kindness	6
information	5
professionalism	5
service	5

What could be improved?	
communication	8
more staff	4
support	2

Feelings	
thank you	57
amazing	19
grateful	13
cared for	12
impressed	12
brilliant	10
compassionate	9
happy	8
reassured	8
reassuring	8

Patient-led assessments of the care environment (PLACE) assessment 2017

Students from Foxes Academy (a specialist catering college and training hotel for young adults with learning disabilities), Musgrove Partners and Patient Care Governors support the completion of the PLACE assessment.

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Assessment Area	2014 %	2015 %	2016%	2017 %
Cleanliness	96	95	99	99
Food	91	90	93	94
Privacy, Dignity and Wellbeing	92	81	87	92
Facilities	90	87	95	93 (national average is 94)
Dementia (New in 2015)	N/A	68	80	86
Disability (New in 2016)	N/A	N/A	79	88

All areas have continued to improve and remain in keeping with the national average except facilities (condition, appearance and maintenance) which has deteriorated and just fallen below the national average.

Patient Experience Collaboration

In September 2017, the Trust committed to collaboration with 10 other trusts, led by Northumbria NHS Foundation Trust, to implement 'real-time measurement'. This collaboration intends to test if real-time measurement is feasible in different organisations and to understand if it can support improvement in those patient experience measures over the year. There are six wards participating at Musgrove Park Hospital and two within Somerset Partnership NHS Foundation Trust, as part of a joint venture within the wider collaboration. The wards participating have a survey based on the national in-patient survey questions asked of 50% of the patients on the ward on a fortnightly basis. The first phase of collecting and establishing the baseline data for the wards was completed in December 2017. Throughout the collaboration the results will be published to the wards on the same day for sharing and where needed for action.

Specialist services seeking feedback

Cancer Services Patient Surveys

There is a rolling programme of patient feedback from the cancer services:

Head and Neck - reported September 2017:
Overall patients were happy with staff attitude

- A few issues were highlighted regarding the comfort of some of the waiting areas.
- Not all patients felt it had been suggested they bring a companion to the diagnosis consultation.
- In the main, patients stated that they were well informed throughout their pathway and the majority felt able to ask questions.
- Patients felt supported by the Clinical Nurse Specialist (CNS), although a few indicated they did not always find it easy to contact her.

Urology - reported June 2017 and action September 2017:

- Waiting room facilities, particularly Surgical Investigation Unit and north-west reception in the Duchess building need upgrading.
- Provision of a written record of consultations and treatment plan to patients.
- All correspondence/calls for appointments to include an invitation to be accompanied by a relative or friend.

Colorectal - June 2017:

- Overall extremely positive feedback with patients reporting how they were treated as individuals and had support from the CNS throughout the pathway.

Skin Cancer reported July 2017 and action August 2017:

- All correspondence/calls for appointments to include an invitation to be accompanied by a relative or friend.
- Highly evaluated service by the melanoma patients.
- North reception facilities reported as needing upgrading.

Radiotherapy reported January 2017 and action May 2017:

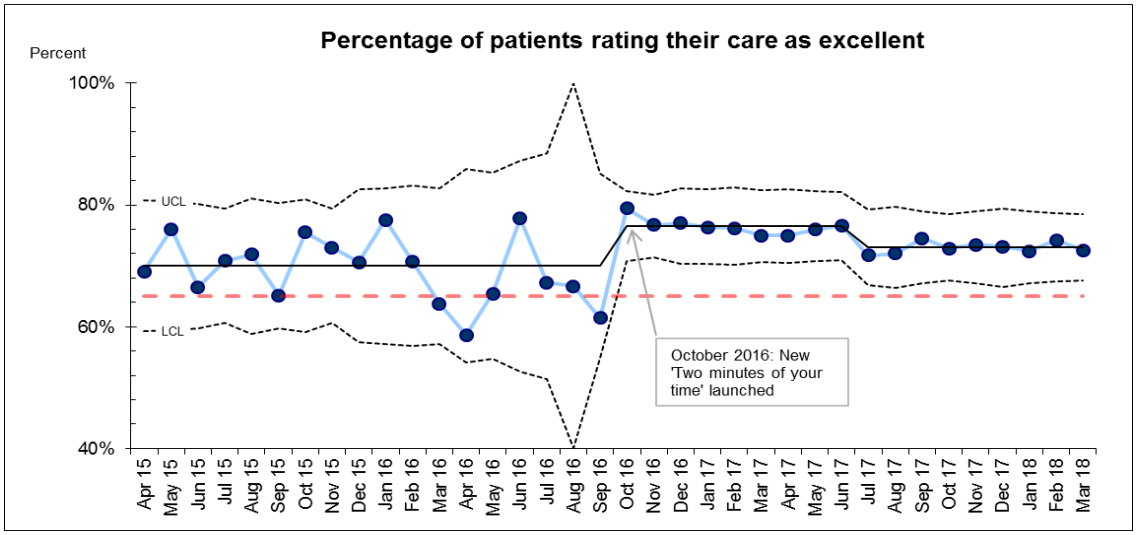
- Treatment machine delays to be verbally communicated to patients in the waiting area.
- Option to designate a quiet area for patients waiting.
- Where possible appointments to be scheduled at similar times each day.
- Doctors to not guarantee specific appointments where this is not achievable.

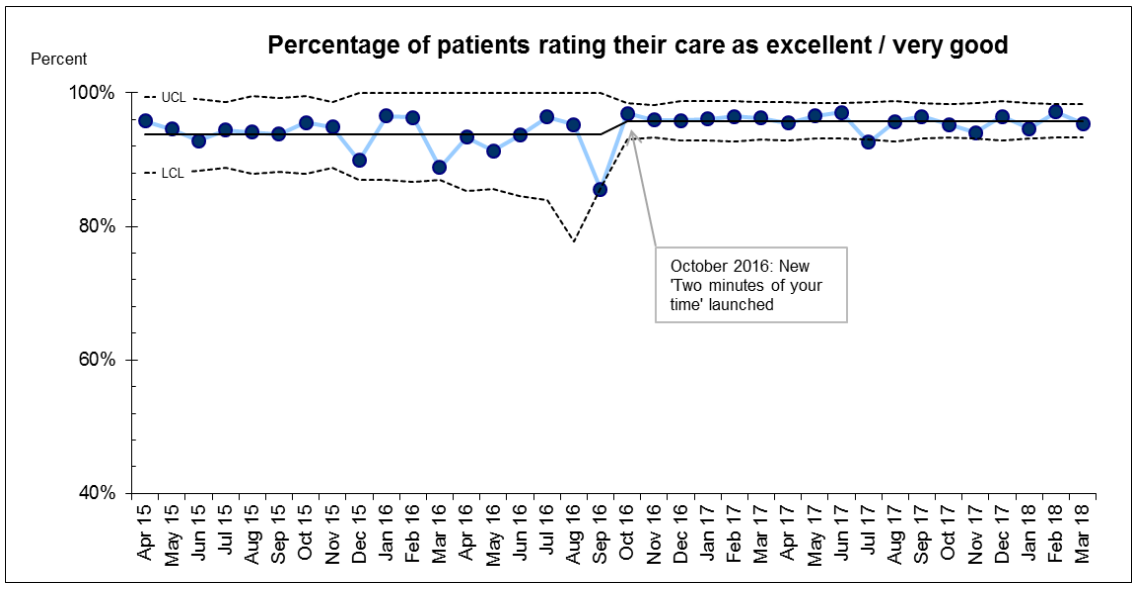
Friends and family (F&F) test - Two Minutes of Your Time survey and One Quick Question surveys

The Friends and Family test is one of the ways that we listen to our patients. It is a national measure that gives patients an opportunity to provide feedback. The results give wards/departments feedback on their care, but are also reviewed nationally to understand the Trust's performance alongside other trusts.

At Taunton and Somerset NHS Foundation Trust, the F&F question is now a part of the two minutes of your time survey for all in-patients, and the one quick question survey for all other areas. This allows the potential for all patients to provide feedback on their experience. Although the Trust is a positive outlier for the results, the response rates are below the national average and have been a focus since September 2017.

The following tables illustrate the Trust's overall rating from patients over time:





NATIONAL SURVEYS

The National Survey Programme provides assurance of broad service coverage within national programmes. The national surveys address:

- Inpatients
- Outpatients
- Children's inpatient and day case
- Maternity
- Cancer patients
- A&E (Emergency Dept.) patients

Participation in national surveys

During 2017/18 five surveys were run nationally: Inpatient, Emergency Department (ED), children and young people, cancer and maternity.

In-Patient summary - Published in May 2017

No. of responses	673	In-patients between August 2016 and January 2017
Overall experience	8.4/10	about the same as other trusts
All topic areas measured scored about the same as other trusts		

There were three areas that the Trust scored better than other trusts:

Involvement in decisions	8.0/10
Not being delayed on day of discharge	7.6/10
Not being delayed for a long time before discharge	8.6/10

There was one area that the Trust scored worse:

Information about medicines to take home (clear written or printed information)	7.3/10

Related specifically to feedback:

Asked to give views about the quality of care	1.1/10
Information explaining how to complain	2.3/10

Both of these are about the same as the national picture, but remain a focus for the patient experience team to improve.

Emergency department (ED) summary - Published October 2017

No. of responses	431	
General ED experience	8.5/10	about the same as other trusts

There were four areas that the Trust scored better than other trusts:

Respect and dignity	9.4/10
Leaving the ED dept.	7.1/10

Care and treatment	8.5/10
Waiting times	6.5/10

There were no areas where the department scored worse than the national picture.

Children and young people summary - Published November 2017

No. of responses	297	
Parents view of child's overall experience	8.6/10	about the same as other trusts

There were two areas that the Trust scored better than other trusts:

Privacy for younger children	9.6/10
Type of ward stayed on	10/10

There was one area that the Trust scored worse:

Understanding what the staff are saying	7.5/10

The national cancer patient experience survey – Published in July 2017

Overall care	9/10	above the national average of 8.7/10
Been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist	90%	scored better than other trusts
Were always treated with dignity and respect	93%	scored better than other trusts
Told who to contact if they were worried about their condition or treatment after they left hospital	95%	scored better than other trusts
GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer	70%	scored better than other trusts

treatment.		
Given the name of a Clinical Nurse Specialist who would support them through their treatment	92%	scored better than other trusts
Definitely involved as much as they wanted to be in decisions about their care and treatment	81%	scored better than other trusts

National Maternity Survey - Published in January 2018

No. of responses	128	
Labour and birth	Summary score 9.2/10	about the same as other trusts
Staff during labour and birth	Summary score 8.9/10	about the same as other trusts
Care in hospital after the birth	Summary score 7.5/10	about the same as other trusts

The Trust scored the same as other trusts in all areas with the exception of 'Involvement in decisions, during labour and birth' which scored 9.1/10, this was better than other trusts.

PATIENT AND PUBLIC INVOLVEMENT (PPI)

Contribution from governors, Musgrove partners and Healthwatch

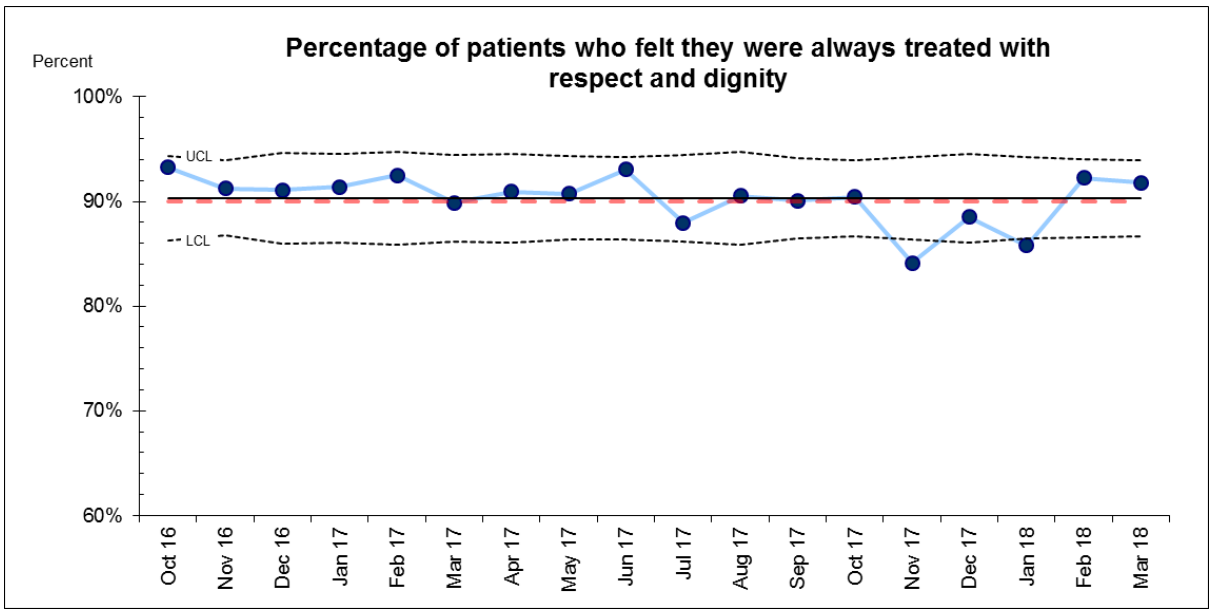
The Trust's governors support the continued patient engagement and feedback agenda, particularly learning from feedback. The governors Patient Care Group regularly reviews feedback from patients/relatives from the local community, which is included in "The Good to Know" log report at their meeting.

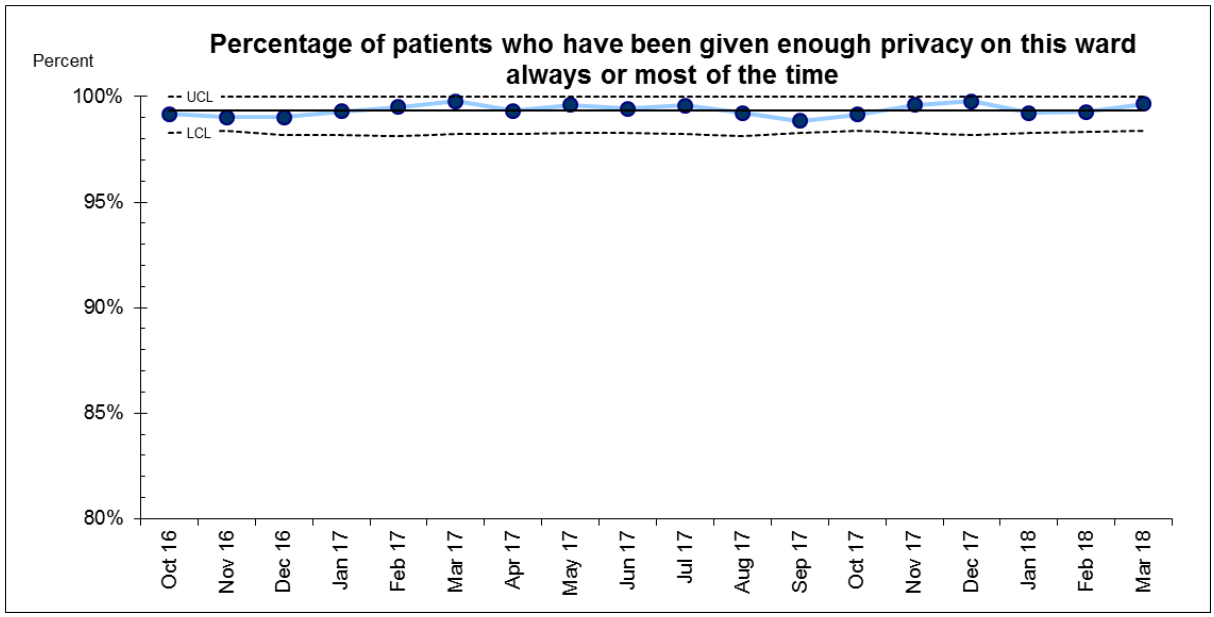
The Trust has established links with Healthwatch and at regular meetings listens to feedback from this route and engages with Healthwatch to support engagement activities particularly with the groups that may be seldom heard.

The Musgrove Partners are a group of Patient Voice Volunteers who support engagement and participate in activities from recruitment of staff to focus groups, reviewing serious incidents, and within the improvement boards and projects. The patient experience team also support observations, shadowing, emotional mapping, focus groups and other engagement events for specific topics.

PRIVACY AND DIGNITY

We recognise that dignity, respect and privacy in care is an important issue for patients who come to us for care and treatment. We are committed to maintaining patient privacy, and treating individuals with dignity and respect. To monitor this we survey our patients and set ourselves the target of 90% positive response. The results are reviewed monthly by the directorates and board.





LEARNING FROM CONCERNS AND COMPLAINTS

The Trust takes concerns and complaints seriously. They are an important opportunity for the Trust to learn and improve. Concerns and complaints can surface and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where complaints are welcomed and learnt from.

In 2017 the following feedback was gathered about complaint handling at the Trust:

Care Quality Commission Feedback - December 2017

Summary

The Trust had systems to identify learning from complaints and make improvements.

The Trust had a team responsible for receiving, investigating and acting on complaints.

The Trust had a low level of complaints.

The number had fallen in recent years, and this was felt by senior staff to be as a result of taking quick action, and attempting to resolve issues before they escalated.

The reduction in complaints was also against a background of the Trust making it easier for people to complain using multimedia options, such as a simple form on the website.

There was a developing culture where meetings were held with complainants at an early stage. It was recognised for some people that this was a significantly better approach than a letter or series of correspondence.

The Patient Advice and Liaison Service (PALS) had moved to be more central within the hospital, and ran stalls around the hospital to bring awareness of its role and offering support and guidance.

Learning from complaints was addressed where it was relevant. Therefore, some learning might be at ward level, some for the estates team, some for departments - such as operating theatres, and others for the whole Trust.

Complaints were reviewed and shared amongst all directorates.

Complaint reports were produced every month by the complaints teams and shared at directorate and specialty team meetings.

Where lessons had been learnt from concerns and complaints it was shared with the complainant.

Four complaint records were reviewed, and it was found that they were responded to in the correct period. Complainants were provided with the action plans developed to address the concerns raised.

We saw evidence that a compassionate and honest response had been provided and a clear written record had been kept of the process. We also saw that an action plan had been written, which included the learning that was to be disseminated to staff.

When complainants were still unhappy after a complaint had been closed by the team, they were signposted to the Parliamentary Health Service Ombudsman (PHSO).

The complaints team contributed to the preceptor nurse-training programme, to educate new nurses about complaints and learning from them.

Feedback for Jowett ward

Complaints were discussed at the daily safety brief. When things went wrong, staff apologised and gave patients honest information and suitable support.

Feedback for Emergency Department

The department treated concerns and complaints seriously, investigated them and learned lessons from the results. These were shared with all staff in the Emergency Department and across the wider Trust, if relevant.

In the departmental meetings some subjects, such as complaints, were discussed each month. There were discussions about learning from complaints, although this was not always easy to see clearly in the minutes.

Feedback for Surgery

People we spoke with knew how to make a complaint.

Information regarding how to make a complaint could be found on the Trust's website, patient information leaflets and posters directing patients to the hospital's Patient Advice Liaison Service (PALS).

Leaflets were available in easy-read format and were available in non-English languages.

Complaints were managed in an appropriate manner. Lessons were learned from complaints.

Minutes of meetings held for surgical and critical board meetings were reviewed and items discussed included complaints and concerns.

Feedback for end of life care

The hospital held weekly palliative care multidisciplinary meetings. Staff from the complaints service attended these meetings once a month.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Complaint reports were shared at directorate and specialty team meetings. This included the detail from a complaint-tracking document, which mapped the progress any complaint process was making.

Outpatients

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Patients and visitors we spoke with knew how to complain.

We saw that action plans were monitored at outpatient department governance meetings.

There were Patient Advice and Liaison Service (PALS) leaflets in the outpatient departments, detailing how to make a complaint.

Managers told us they preferred to speak with patients about complaints and resolve them as soon as possible.

In outpatients, the complaints and PALS officers set up a table for two hours per week for patients and staff to discuss any issues.

THE PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

In 2017/18, 160 complaints investigated: 35 not upheld, 16 upheld and 93 partially upheld (16 still under investigation)

During the year the 692 concerns were raised through the Patient Advice and Liaison Service (PALs).

All of these concerns are investigated and feedback given to the person who raised the issue. This includes setting out what staff have learnt and any changes made as a result of the questions raised. The Trust aims to avoid cause for concerns or complaints in the first instance, and where concerns and complaints are raised to address them thoroughly and in a timely way.

Every complaint is reviewed to identify the issues raised. This is to ensure that we can learn and continuously improve. The categorisation of issues identified for all complaints is recorded and reviewed to allow wider learning and identification of trends. This is considered alongside other patient information such as incidents and feedback gained from monthly patient surveys.

The monthly integrated performance report includes a range of quality indicators which includes response times to complaints. During the year, learning from complaints has been shared across the hospital in a number of ways, including the use of patient stories and hearing directly from patients and their relatives about their experience.

The following are examples of the learning and improvements that have been made:

- A patient was admitted for surgery to remove an ectopic pregnancy; she was very unhappy that she was discharged from hospital without any advice or detailed instructions.

  As a result of the complaint investigation the senior sister and consultant involved agreed to produce a patient information leaflet for patients discharged from hospital, specifically for women who have experienced an ectopic pregnancy and subsequent surgery. Sister worked with staff and patients from the Early Pregnancy Assessment Clinic and the gynaecology team to design the leaflet. The leaflet will include practical advice regarding bleeding post-surgery and information on where women can seek further emotional support if required.

It is important that any themes are identified and action taken.

- A patient was due a six-month follow up appointment but was removed from the department's list citing that the patient no longer wished to have

the operation. However, neither the patient nor the consultant had made this request.

As a result of the investigation, procedures have been taken to prevent patients being removed from surgical waiting lists without checking that this is the correct action and that the patient is aware of our actions. In future, the admissions team agreed that they need to speak directly to the patient and the consultant's secretary to ensure that the correct information is communicated.

The PHSO provides an independent complaints handling service for a range of public bodies. Should any of our complainants be dissatisfied with the handling and outcome of their complaint, they have the right to request the Ombudsman to undertake an independent review. We ensure that every complainant is given information about the role of the Ombudsman.

The Trust has seen a decrease in the number of cases referred to the Ombudsman this year, with seven new cases referred, compared to 14 last year.

Of the seven that have been referred this year, two have not been upheld and five remain under investigation.

CLINICAL EFFECTIVENESS

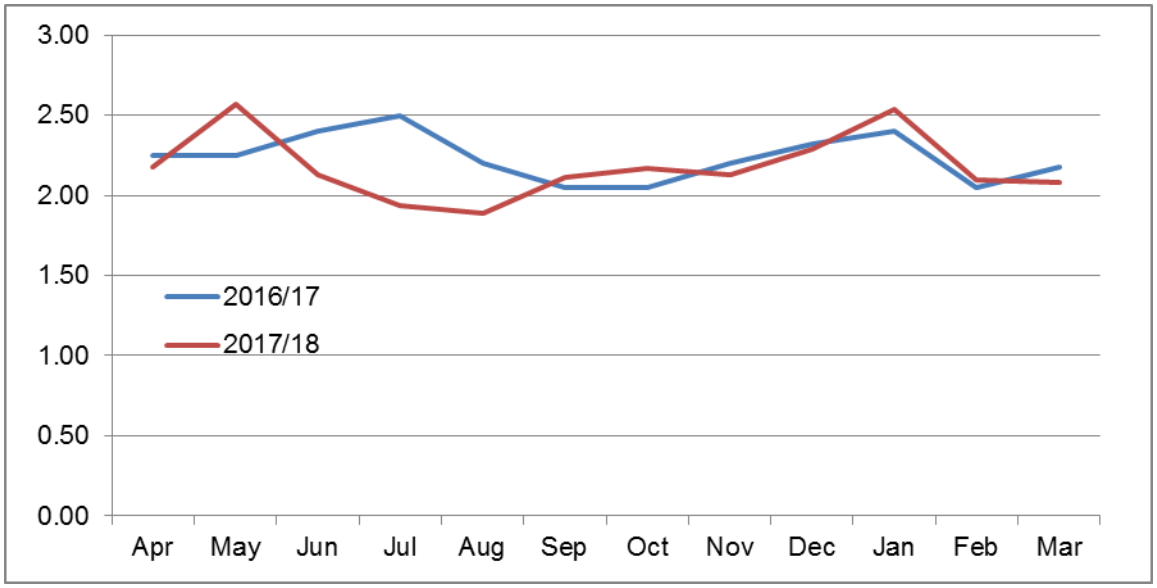
LENGTH OF STAY

The Trust strives to ensure that patients do not stay in hospital for any longer than is clinically necessary. This ensures patients receive the best care in the right setting, whilst also ensuring the Trust uses its resources effectively.

Reports on average length of stay are monitored in regular Trust Board reports and at a more detailed level by each directorate in their monthly Performance Assurance Framework (PAF) reviews.

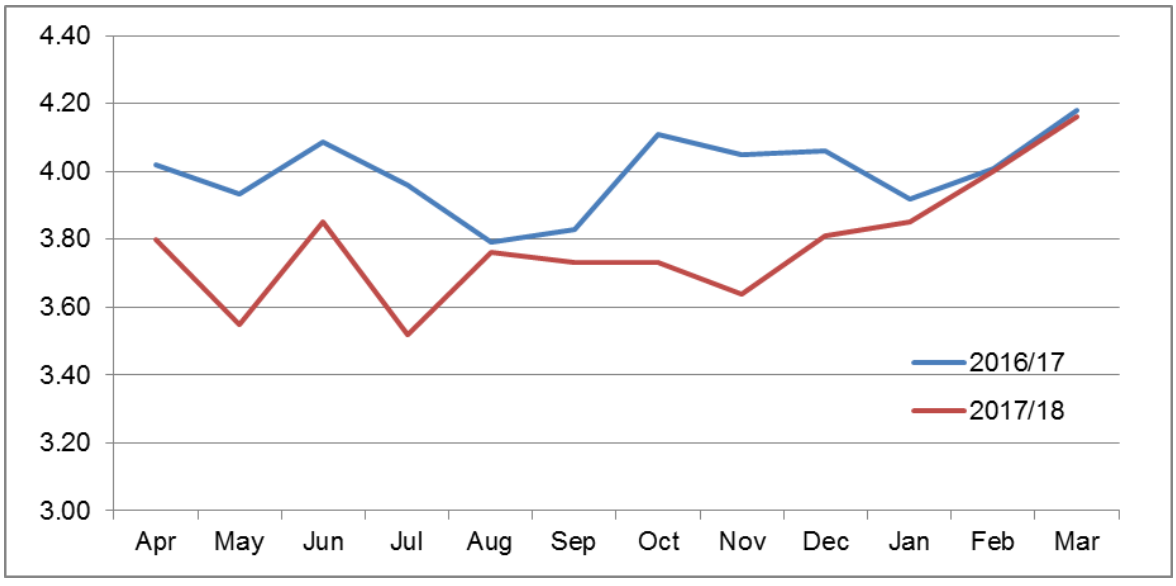
The following charts show the average length of stay for elective and non-elective patients in 2017/18 and the previous year. The Trust would typically expect average elective length of stay to be below non-elective as elective activity is more predictable and planned. Emergency cases are often more complex and so need longer treatment and recovery periods.

Elective Average Length of Stay



The average length of stay for patients admitted for elective operations during 2017/18 was below the level reported in 2016/17 over the summer months, and at similar levels to the previous year for most other months. The average length of stay of patients discharged in January 2018 may have been higher than in January 2017 because of the very high levels of emergency admissions in the month which resulted in a high proportion of routine surgery being cancelled. Those operations which did go ahead were the more clinically urgent and hence more complex operations, for which patients would usually stay longer in hospital.

Non-Elective Average Length of Stay



The average length of stay for patients admitted non-electively during 2017/18 was also below that reported in 2016/17. The reduction in length of stays between years was most significant in October and November, when the seasonal rise in

stays is usually seen. This reduction in the length of stay in hospital for emergency patients is likely due to the implementation of the Home First model of care, which commenced in October 2017. Home First facilitates the discharge of Medically Fit for Discharge patients out of the acute trust. Patients receive an intensive period of reablement in three settings to promote independence and keep patients (for as long as possible) in their usual place of residence. The length of stay of non-elective patients discharged from January 2018 increased to the levels seen in the same period in the previous year. The length of stays across the last quarter of the year were likely affected by the closures of wards affected by norovirus, with some patients' stays needing to be extended until they were well enough to leave hospital.

CANCER WAITING TIMES

During 2017/18 the Trust performed well against the four 31-day decision to treat to treatment waiting time standards, achieving the target for the year as a whole and in most months of the year. These standards cover the waiting time from decision to treat through to the time when treatment commences, for patients with a first cancer and those needing subsequent treatment. The 62-day wait from referral to treatment, for patients referred by one of the three national screening programmes (breast, cervical and bowel) was also achieved for the year as a whole and in most months of the year.

However, the Trust under-performed against the two-week wait targets for 'symptomatic' breast patients (where cancer is **not** suspected) and for patients referred by the GP with a suspected cancer, and for the 62-day wait from referral by a GP with a suspected cancer, to treatment.

The under-performance against the two-week wait standard for symptomatic breast patients was mainly due to staffing challenges, with a shortfall in certain months of specialist radiologists to support outpatient clinics, and also patients refusing to accept appointments offered within the first two weeks of referral. The breast service is the only one where the national standard is that all patients referred have to be seen within two weeks of referral, regardless of whether or not cancer is suspected. Where cancer is not suspected, these are referred to as symptomatic breast patients. We are continuing to work with our commissioners and GP colleagues to try to ensure that patients are only referred in when they are willing to accept appointments within two weeks, even when cancer is not suspected.

Performance against the two-week wait standard for patients referred by their GP with a suspected cancer has been variable during 2017/18. During January and February 2018 performance was significantly above the 93% national standard. However, performance for the remainder of the year has been below the national standard. The two main reasons for patients not being seen within two weeks of

referral has been, a shortfall in capacity within the CT (computerised tomography) scanning service and patients choosing to delay appointments. There has been a marked increase during 2017/18 in the number of referrals made by GPs for patients with a possible lung or colorectal cancer, and it is these patients who are most likely to need a CT scan as their first diagnostic test. Additional CT capacity was established from December 2017, which helped to bring waits down to consistently less than 14 days. Plans are in place to establish an additional on-site CT scanner during 2018/19, which will help to ensure waiting times remain within the target 14 days.

The growth in two-week wait referrals has also resulted in further challenges in achieving the 62-day GP referrals to treatment standard, because this is the first step in the 62-day GP pathway. The 62-day wait for treatment is an important measure of clinical effectiveness for the Trust. The 62-day target is defined as follows:

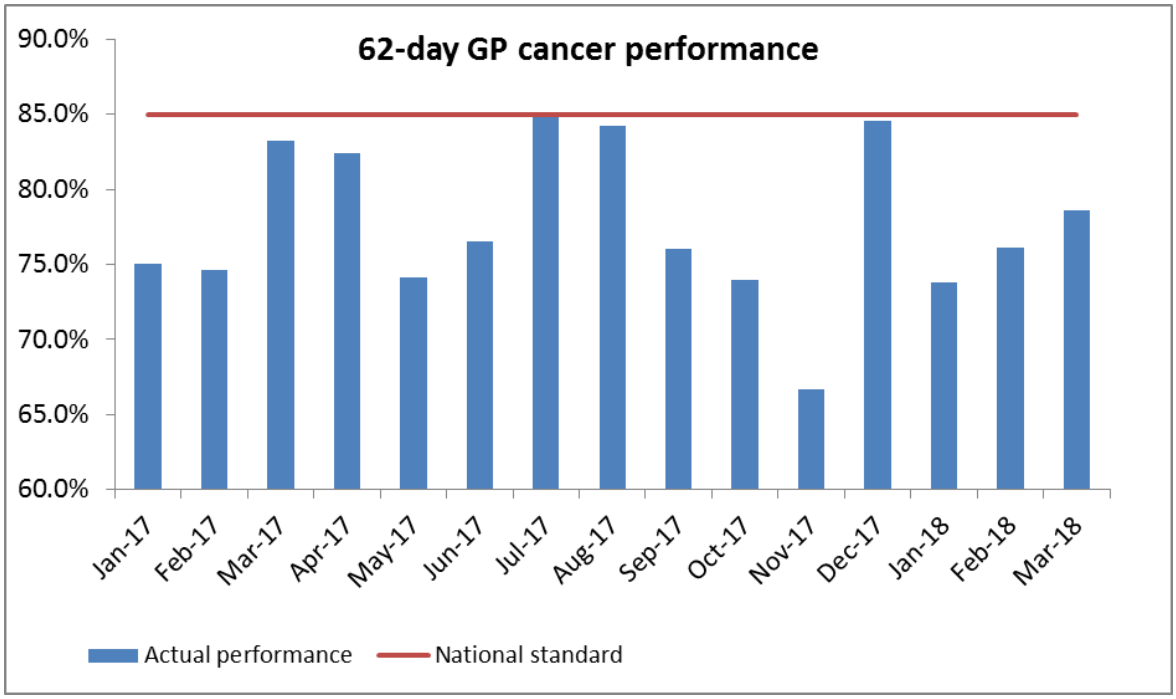
- The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer or a referral from one of the screening programmes (bowel, cervical or breast);
- The above standards are counted separately;
- An urgent GP referral is one which requires a two-week wait from the date that the referral is received to first being seen by a consultant;
- The clock start date is defined as the date that the referral is received by the Trust.

The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice.

In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition; or it is the date that cancer was discounted when the patient was first seen; or it is the date that the patient made the decision to decline all treatment.

Like many trusts across the country, Taunton and Somerset NHS Foundation Trust did not achieve the 85% target for the 62-day GP standard during 2017/18. The reasons for the failure to achieve the standard included the complexity of patients being referred, the high levels of referrals not being able to be matched by service capacity, especially for diagnostic tests such as CT, MRI and endoscopy; patients choosing to delay diagnostic tests or treatment, and delays for patients being seen for specialist treatment at other providers. The Trust held a Cancer Summit early in the year, getting together a range of clinical, managerial and administrative staff to understand the reasons behind potential delays in cancer pathways. This generated a range of new ideas, from which a Cancer Improvement Plan was developed with work-streams including ways to reduce

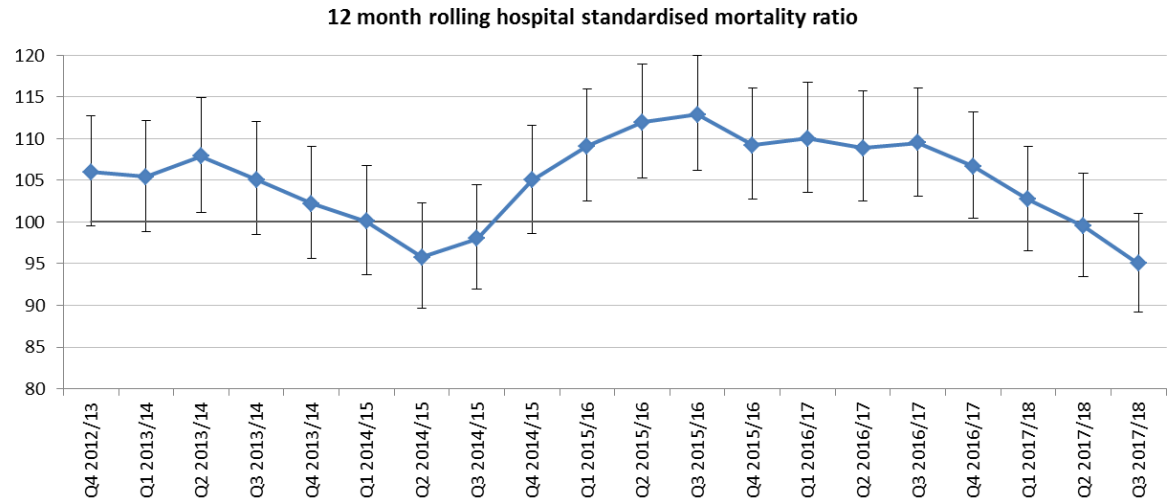
diagnostic delays and the redesign of a number of cancer pathways. This plan will continue to be implemented and added to in 2018/19. Compliance with all cancer targets continues to be closely monitored by the Trust Board.



HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

The hospital standardised mortality ratio (HSMR) is a method of comparing mortality against the predicted national average but taking into account a range of factors such as the case-mix of patients, palliative care cases and differences in populations. It is calculated on 56 diagnosis groups that account for around 80% of in-hospital deaths. The ratio is of actual deaths to expected deaths, multiplied by 100. If the number of deaths is higher than would be expected, the HSMR will be greater than 100. Mortality rates show considerable variation over the short-term which means that observing them over longer periods of time (12 months) provides a better perspective on genuine trends. It is important to highlight that there is no statistically significant association between hospital-wide mortality rates and avoidable deaths, nor with the quality of hospital care. Whilst the methodology for HSMR may take into account factors such as palliative care, there are differences in the way trusts code this data which may make comparisons less reliable.

The following graph illustrates the Trust's quarterly overall rolling 12-month HSMR over the last three years. The HSMR is currently in the 'as expected banding', suggesting the Trust's in-hospital mortality rate is not significantly different than the national average.



HSMR is presented alongside the 95% confidence intervals. Where the lower confidence interval exceeds 100, the HSMR is said to be significantly higher than expected. Where the confidence interval spans 100, the HSMR is within the expected range.

In order to explore the root causes for this position, the Trust reviews individual diagnostic groups and conducts investigations to identify the causes when these are different from those expected. It should be noted that small variations are not necessarily accurate reflections of changes in the standard of care as these are statistical representations with certain inherent errors. It is most valuable in detecting major deviations or trends.

During 2017/18 the Trust has conducted a number of reviews into its high standardised mortality ratios within certain diagnostic groups that contribute to the overall high HSMR. These diagnosis groups include pleurisy, pneumothorax, pulmonary collapse, acute myocardial infarction, and hip fracture. The investigations consist of a review of coding practices, case mix and the structure of our services. It also includes a review of the quality of the care the Trust was delivering. The reviews found no significant causes for concern relating to the quality of care being delivered. During the year, some Improvements to co-morbidity coding and changes to palliative care coding have been made.

ORGAN DONATION

The Trust continues to implement national and regional best practice and remains compliant with NICE guidance (CG 135). An outstanding referral rate of potential organ donors has been achieved (96.5%) and our collaborative approach rate of 80% remains in line with the national average.

The overall consent rate for organ donation within the Trust is 64%; reflecting the national average of 63%. As a result, the Trust continues to perform well in terms

of organ donation with a total of nine transplants enabled over the year. Of note, is the number of organs donated per donor which has increased from the previous figure 2.8 up to 5.3 organs per donor. This indicates good clinical management of our potential organ donors and is well above the national average of 3.4 organs per donor.

Key work for 2017/18 will be a continued focus on the NHS Blood and Transplant national strategy concerning the end of life care and organ donation management of patients from the Emergency Department following devastating brain injury.

NHS STAFF SURVEY 2017 / PULSE CHECK

Taunton and Somerset NHS Foundation Trust strongly believes that whilst our core value is 'putting the patient first', our culture and significant organisational development programme is founded on a belief that person-centred care can only be delivered through a person-centred culture. Therefore, the Trust places significant value on the insight provided by both the NHS staff survey and the internal engagement measure, 'Pulse Check'.

2017 NHS staff survey

The 2017 NHS staff survey results show overall staff engagement. A score based on a number of key questions which can be used as a benchmark against other acute hospitals is 3.92 for 2017, which shows the Trust having an increase over the score in 2016 which was 3.89. The key findings which make up the overall engagement score relate to: staff members' perceived ability to contribute to improvements at work; their willingness to recommend the Trust as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work. The table below sets out the specific questions which make the key findings with the results for 2014-17.

Question	2017	2016	2015	2014	Acute hospitals (2017)	Difference against national benchmark +/-
I look forward to going to work	61%	60%	67%	55%	58%	+3%
I am enthusiastic about my job	77%	76%	78%	71%	74%	+3%
Time passes quickly when I am working	79%	78%	78%	71%	77%	+2%

Question	2017	2016	2015	2014	Acute hospitals (2017)	Difference against national benchmark +/-
There are frequent opportunities for me to show initiative in my role	75%	75%	78%	69%	73%	+2%
I am able to make suggestions to improve the work of my team / department	78%	79%	78%	79%	74%	+4%
I am able to make improvements happen in my area of work	58%	57%	60%	55%	56%	+2%
Care of patients / service users is my organisation's top priority	84%	84%	85%	74%	76%	+8%
I would recommend my organisation as a place to work	72%	71%	74%	63%	61%	+11%
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	84%	84%	82%	78%	71%	+13%

Harassment, bullying or abuse from staff in last 12 months and equal opportunities for career progression

Key finding 26 of the 2016 NHS Staff Survey sets out the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months as 23%. This is a reduction since the 2015 survey of 7% and below the average for acute trusts of 25%. The NHS Staff Survey report recognises this as a statistically significant movement in the right direction. This key finding is made up of two questions:

Question	2017	2016	Acute hospitals (2017)
% never experiencing harassment, bullying or abuse at work from managers in the last 12 months	91%	90%	87%
% never experiencing harassment, bullying or	82%	83%	81%

Question	2017	2016	Acute hospitals (2017)
abuse at work from other colleagues in the last 12 months			

Following on from the work undertaken in 2016 further work was done Trust-wide. This involved running focus groups throughout the early part of 2017 and providing opportunities for all colleagues to attend a session and have a discussion around some specific questions. These questions centred on trying to further understand the reality of some of the issues colleagues are facing and how best we can support them and reduce the experiences of harassment, bullying or abuse they are feeling from other colleagues, patients and managers. The output of the focus group has now seen a small working group in place with representation from across the Trust to turn the feedback that we have heard and collated into positive action. Some of the things that are in place already include training around how to have a meaningful conversation with people and resilience training. We are also working in partnership with our alliance colleagues and have started to provide training to front line colleagues on mental health awareness and de-escalation techniques.

The score for the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion, remains at 88%. This key finding is based on one question: '% saying the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

Staff conversations / listening to staff

The People Partner team have continued to take forward interventions and build on the previous years' work, which has now been expanded across to Somerset Partnership. These interventions have included mini-conversations where teams have been given the opportunity to facilitate conversations around team dynamics, behaviours and culture, and enabled them to come up with some actions that they can commit to, in order to improve in these areas. The group has also been involved with team building sessions, supporting new teams that are coming together, and facilitating them to build relationships that will enable strong group support foundations for taking the future of their services forward.

Pulse Check

Launched in 2014 Pulse Check is the key people metric, with a strong focus on discerning how colleagues feel about how they are being led by their line manager at a local level. Pulse Check runs twice per year for each directorate, asking the

same 14 questions so that the results can be compared. Each directorate receives a report showing a breakdown of their results for every department which has over eight responses. This enables managers at a local level to understand how colleagues are feeling compared with the wider directorate and the hospital overall. The view provided by Pulse Check across the whole Trust enables celebration of areas that are doing well and identifies areas which need further support.

As part of the people metrics for the Trust, five of the 14 questions are amalgamated into the leadership capability index, which is the key measurement used to identify how well managers are leading their teams in line with the Trust's leadership behaviours.

The five questions used to make up this index are:

- I think that it is safe to speak up and challenge the way things are done;
- My immediate manager motivates and inspires me to do a great job;
- My immediate manager recognises and acknowledges when I have done my job well;
- My immediate manager makes time to see me when I need support or direction;
- I receive regular and constructive feedback on my performance.

The following table shows the percentage of respondents responding positively to the questions during 2017/18 for the Trust as a whole:

Question	Q1	Q2	Q3	Q4	Q1:Q4 +/-
How likely are you to recommend this organisation to friends and family if they needed care or treatment?	94%	96.5%	88.9%	96.2%	+2.2%
How likely are you to recommend this organisation to friends and family as a place to work?	76.4%	83.5%	68.9%	82.9%	+6.5%
Leadership Capability Index (Amalgamation of following five questions)	70.5%	78.9%	67.1%	79%	+8.5%
I think that it is safe to speak up and challenge the way things are done	70.1%	74.7%	61.7%	75.1%	+5%
My immediate manager motivates and inspires me to do a great job	69.2%	79.7%	68.9%	79.3%	+10.1%
My immediate manager recognises	70.1%	79.4%	69.2%	80.7%	+10.6%

and acknowledges when I have done my job well					
My immediate manager makes time to see me when I need support or direction	80.4%	87.8%	77.4%	85.9%	+5.5%
I receive regular and constructive feedback on my performance	62.5%	73.2%	58.6%	74%	+11.5%
I believe that we are providing high quality services to our patients/service users	91.8%	92.2%	85.1%	92.2%	+0.4%
I feel that quality and safety of our patient care is our hospital's top priority	86.6%	86.5%	80.5%	90.1%	+3.5%
I have the tools and equipment I need to do my job well	73.5%	74.3%	63%	75.9%	+2.4%
When we get things wrong I feel that we learn and make changes to improve	78.5%	84.7%	69.2%	82.9%	+4.4%
I feel respected and valued as a member of my team	74.3%	82.1%	67.9%	79.7%	+5.4%

Question	Q1	Q2	Q3	Q4	Q1:Q4 +/-
My immediate manager places a strong emphasis on promoting safety and wellbeing of colleagues	72.7%	82.9%	75.6%	80.9%	+8.2%
The senior leaders of this organisation are doing the right things in line with our values, for Musgrove Park to be successful.	56.5%	69.7%	44.1%	70.4%	+13.9%

Preceptees / Assistant Practitioners and Band 5 Intensive Care Unit

Quality Improvement continues to be supported in the Trust's preceptorship programme.

New preceptees come into the hospital with fresh eyes, energy and new ideas that encourage staff to think differently and challenge the way they work. The preceptees may not feel that they have the skills to challenge or to suggest new innovations, yet they see problems and want to work on solutions. The preceptees have structured time around quality improvement during their programme which allows them to develop their ideas in a structured and supported environment.

The preceptees present their projects to invited guests from the improvement network, senior nurses, line managers and to those staff helping with the transition and sustainability of the work.

Examples of some of the Improvement projects to be presented in the next month from the last two courses are:

- Standardised safety brief
- Names on theatre hats
- Pain management post laparoscopic gall bladder removal
- Patient information leaflet for vac dressing
- Redesign of daily weight chart.

The Leadership Talent Programme 2017/18

Lead has continued to be the main in-house leadership development programme and has been extended to Band 4 and Band 3 colleagues. This is in line with our leadership ethos that leadership is for everyone and the programme continues to focus around leadership behaviours, impact, choices and coaching.

- The impact of the in-house leadership programme for colleagues and for the Trust continues to be monitored by Pulse Check and at the end of 2017 (quarter 3) the leadership capability measure was 73.9%.
- The provision of a leadership development programme is currently being reviewed along with the values and behaviours. The revised leadership development programme will continue to build on the work of previous years and will strive to ensure we continue to enable colleagues to be the best they can be now and in the future.

NATIONAL TARGETS AND REGULATORY REQUIREMENTS

Key Targets	Threshold	2013/14	2014/15	2015/16	2016/17	2017/18
Maximum 18 Week waits from point of referral to treatment in aggregate – patients on an incomplete pathway** Ⓐ	92%	93.0%	91.95%	91.24%	85.5%	83.6%
A&E maximum waiting times of four hours from arrival to admission /transfer / discharge*Ⓐ	95%	96.0%	95.1%	94.1%	91.8%	90.8%
Cancer: two week wait from referral to date first seen – all urgent referrals (cancer suspected)	93%	94.8%	89.3%	92.5%	93.4%	91.1%
Cancer: two week wait from referral to date first seen – for symptomatic breast patients (cancer not suspected at referral)	93%	95.9%	90.0%	95.8%	91.9%	90.9%
All cancers: 31-day wait from diagnosis to first treatment	96%	98.8%	94.9%	97.9%	97.8%	97.6%
Maximum waiting time of 31 days for subsequent treatments where subsequent treatment is surgery	94%	97.9%	94.0%	96.0%	97.2%	96.5%
Maximum waiting time of 31 days for subsequent treatments where subsequent treatment is Drugs	98%	99.9%	99.9%	100%	100%	100%
Maximum waiting time of 31 days for subsequent treatment where	94%	99.1%	99.2%	98.3%	97.5%	96.8%

Key Targets	Thresh-old	2013/14	2014/15	2015/16	2016/17	2017/18
subsequent treatment is Radiotherapy						
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer*	85%	89.1%	82.6%	83.2%	80.8%	77.4%
All cancers: 62 day wait for first treatment from NHS Cancer screening service referral	90%	95.4%	89.5%	91.3%	87.9%	95.2%
MRSA	1	2	0	0	1	3
Clostridium Difficile - meeting the Clostridium Difficile objective	(Variable)	13 (15)	13 (11)	22 (12)	8 (12)	18 (12)
Cancelled Operation: Offered another binding date within 28 days	95%	97.1%	97.3%	97.7%	92.7%	92.1%
Maximum Waiting Times: Rapid Access Chest Pain Clinics (14 days)	100%	100%	100%	100%	100%	100%
% Stroke patients direct admission to Stroke Unit within 4 hours	80%	72.3%	71.7%	71.9%	66.7%	69.7%
Summary Hospital-Level Mortality Indicator (also included in quality accounts regulations)	100.0	100.9	99.4	101.1	97.0	82.8
Maximum 6-week wait for diagnostic procedures	99%	99.0%	93.2%	92.6%	92.8%	91.3%
Venous thromboembolism (VTE) risk assessment	95.0%	95.4%	94.8%	93.7%	94.3%	94.9%* provisional

**A&E maximum waiting times - the indicator is expressed as a percentage of all A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge*

*** RTT incomplete pathways – the indicator is expressed as the percentage of patients on an incomplete pathway (i.e. those still awaiting first consultant led treatment) who have waited less than 18 weeks from referral.*

ANNEXES

Annex 1: Statements from Stakeholders

NHS Somerset Clinical Commissioning Group Report

As Lead Commissioner, NHS Somerset Clinical Commissioning Group (CCG) has monitored the safety, effectiveness and patient experience of health services at Taunton and Somerset NHS Foundation Trust 2017/18. The Trust has engaged with the CCG in the quality contract monitoring process to provide the basis for the CCG to comment on the Quality Account including the Trust performance against Quality Improvement priorities and the quality of data included.

From the data supplied the CCG can confirm the Quality Account appears materially correct. The CCG congratulates the Trust on its Care Quality Commission (CQC) overall rating of "Good" when it was inspected in August 2017 with *outstanding* in the Caring domain. The CCG notes the Trust is undertaking improvements to improve their performance on the *safe* domain.
The old buildings at Musgrove Park has been an ongoing challenge so it was good news that in March 018 the Trust was given the go ahead from the Department of Health and Social Care for the development of state-of-the-art theatres, a Critical Care Unit and Endoscopy Suite. It will replace most of the ageing 1940s buildings that currently provide care for some of the most critically ill patients. It is expected that patients could be operated on and cared for in a new £79.5 million surgical centre by the end of 2023.

In 2017 Musgrove Park Hospital and Somerset Partnership – the NHS provider for mental health and community services – joined forces to provide more seamless care for local people. The Boards at Taunton and Somerset NHS Foundation Trust (Musgrove Park) and Somerset Partnership NHS Foundation Trust have agreed a formal collaboration and have created one joint executive management team with a single Chief Executive to oversee the collaborative working and provide seamless care for patients. The collaboration has enabled a wider review of the workforce challenges in Somerset with significant registered staff vacancies and wider opportunities for staff retention.

Quality Improvements 2017/18

The Trust welcomes assurance visits from the CCG and encourages attendance at their meetings including the Trust internal Quality Assurance Committee meeting. During 2017/18 the CCG visited the Accident and Emergency Department (ED) and found the department to be effectively managed with good links and escalation processes linked to the wider hospital including a well-run and

GP lead minor illness service, with good links to the out of hour's service. We have in addition visited the Intensive Care Unit and reviewed care of patients who have had long waits for treatment.

The Trust has launched numerous quality improvements which have improved patient safety, clinical effectiveness and patient's experience. The CCG in particular notes the Integrated Front Door (IFD) approach which is performing well and through its practice is encouraging collaborative working across the Health and Social Care Community across Somerset. The Trust was ranked 38 out of 137 trusts for December's 2017 4-hour A&E performance (patients seen, treated, and admitted or discharged in under four hours from arrival at the ED front door) with the Trust seeing a 15.1% increase in emergency admissions via the Emergency Department, relative to the same month in 2016 before the IFD was implemented.

In continuance of its collaborative working the Trust has worked well with commissioners and other stakeholders at implementing the National Home First discharge project which in Somerset is funded through the Joint Commissioning Board (Somerset Local Authority and the CCG). The Trust has reported 429 patients have used the Home First service from their hospital site with the average age of the service user having the benefit of this extra support on discharge, being 86 years.

The Trust is a one of 16 NHS national Digital Exemplar sites delivering exceptional care, efficiently, through the use of world-class digital technology and information. Exemplars are sharing their learning and experiences to enable other trusts to follow in their footsteps as quickly and effectively as possible. All Acute Digital Exemplars are now partnered with fast followers – trusts who will support the spread of best practice and innovation.

Patient Safety

The Trust continues to work closely with the CCG and other stakeholders in Somerset to improve infection control and prevention with shared learning. The Trust aim was to have no Methicillin-Resistant Staphylococcus Aureus (MRSA-bacteria) Trust-apportioned bloodstream infections but unfortunately had three cases in 2017/18. Multi-disciplinary reviews identified improvements for MRSA screening and checking for any previous history of MRSA on admission.

Musgrove Park Hospital continues to drive quality improvements to reduce the number of Clostridium difficile cases by completing Post Infection Reviews to determine whether there were any lapses in care that could have contributed and to identify learning. The reviews are then validated by the CCG and used for learning across the County. In 2017/18 there were 15 Trust attributed cases with 3

of the cases suggesting a lapse in care which the Trust addressed by implementing a change in the environmental cleaning system.

The Trust is to be congratulated on achieving above the National standard for assessing patients on admission for the risk of blood clots performing a fundamental principle in keeping our patient safe.

There have been 8 Serious Incidents reported in the year by Musgrove Park Hospital. Two of the incidents are to be requested to be downgraded because following investigation one incident does not meet the criteria for a Serious Incident. The second incident to be removed was a suicide of a staff member, this has been reported by another Trust and it has been agreed the reports will be amalgamated and learning shared across both Trusts.

There have been two Never Events recorded during the period, a Retained guidewire and Cross-matching error – this Serious incident was attributable to the Laboratory and was recorded by Musgrove but the incident is not attributable to the Trust. There have been no reoccurring themes identified during the period.

Clinical Effectiveness

The Trust performed well against the cancer target 31-day decision to treat to treatment waiting time standards, achieving the target for the year as a whole and in most months of the year. The 62-day wait from referral to treatment, for patients referred by one of the three national screening programmes (breast, cervical and bowel) was also achieved for the year as a whole and in most months of the year. It underperformed against three of the cancer performance targets; 2-week wait targets for ‘symptomatic’ breast patients (where cancer is not suspected) and for patients referred by the GP with a suspected cancer, and for the 62-day wait from referral by a GP with a suspected cancer, to treatment. The Trust has put in place a Cancer Improvement Plan to improve its performance and is working with the Cancer Alliance across the South West to help drive improvement in performance for its cancer patients.

The Mortality Surveillance Group (MSG) now meets monthly following national guidance to review deaths, establish if avoidable, identify learning, initiate investigation if significant concerns and cascade learning to Trust staff. The MSG have reviewed 532 deaths 2017/18 with 3 full investigations for lapses in care completed and learning identified.

Patient Experience

The CCG congratulates the Trust on their CQC (Care Quality Commission) Inspection 2017 feedback which noted the Trust had engagement with the

patients, carers, public, staff and stakeholders. In particular, noting the urgent and emergency department which valued feedback from patients and also surgery with positive Friends and Family test results. This reinforced the Trust Quality Improvement venture of the Integrated Front Door (IFD); following a Trust survey on patients experience the results:

46% said they were seen and treated more quickly through the IFD than their previous service experience
36% said both times they experienced very good service
15% said they received the same level of service with the IFD as before

The Trust received positive publicity in January 2018 when it was named as the second best hospital in England for its healthy food and drink by the Health Business magazine. A Trust inpatient survey June 2017 showed 94.7% of the patients received the help they needed with eating which is a good performance although did decline to 66% in September 2017.

The Trust has improved its performance on its Patient Led Assessments on the care environment (PLACE) which is a system for assessing the quality of the hospital environment with exception to the lower than national score for facilities. Best performing areas included cleanliness which scored 99% and also improved scores from 79% to 86% for Dementia and 79% to 88% for disability.

The Trust is to be credited for its collaboration with ten other Trusts to implement real time measurement of patient experience which will bring an added patient voice to patient experience using its services and from this lead improvements and innovation across its services.

Quality Improvement Priorities for 2018/19

The CCG supports the Quality Improvements identified by the Trust for 2018/19:

- Learning from deaths
- Safer Care
- Mental Health and holistic care
- Patient Experience
- Right Care, Right Time, Right Place
- Staff Retention and Wellbeing

The CCG looks forward to continuing our good working relationship with the Taunton and Somerset NHS Foundation Trust to support improved clinical effectiveness, patient experience, patient safety and the Quality Improvements over the coming year.

Please contact me at the address above if you wish to discuss the CCG comments or statement further.

Sandra Corry, director of quality, safety and engagement

Healthwatch Somerset's Response to Taunton & Somerset NHS Foundation Trust Quality Account 2017/18

Introduction

Healthwatch Somerset welcomes the opportunity to comment on the draft Taunton & Somerset NHS Foundation Trust Quality Account 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 Healthwatch Somerset has not been directly involved in the development of quality priorities this year, we note that the topics were developed through wide consultation with staff, governors and patient representative groups. This included quarterly meetings with Healthwatch Somerset to review progress against the individual quality improvement priorities. 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:

Learning from deaths

We support action by the Trust to reduce the number of preventable patient deaths whilst in hospital. Learning from deaths is a key priority to help improve care and ensure patient safety within Musgrove Park Hospital. We note that mortality data is used to aid learning within the Trust and to identify those areas where care has been inadequate. We commend proposed action by the Mortality Surveillance Group to monitor patient outcomes and ensure clinically effective care, and to ensure that the systems to review deaths are fit for purpose. We also commend any action taken to ensure that the outcomes of any investigation, including action to improve procedures, are shared with patients and their relatives.

Safer care

Patient safety has to be a key priority in any hospital and we fully support action to reduce avoidable harm across Musgrove Park Hospital. This includes a sustained improvement in sepsis management, a reduction in the incidence of hospital acquired infection, a reduction in the number of falls, and a reduction in the incidence hospital acquired pressure ulcers which we know has been one of the key safety priorities at the Trust for several years.

Mental health and holistic care

We know that the benefits of integrated care across boundaries (health, social care, employment and housing) are understood. However, integrated care for people mental health conditions is often the exception rather than the rule. This can lead to poor patient experience and reduced quality of care. We note that a priority for the Trust is to increase the capability of staff to recognise and respond to those patients with mental health needs (children, adults in crisis and older people). The Trust's developing partnership with Somerset Partnership NHS Foundation Trust should mean closer working between physical and mental health care services and a greater opportunity for better mental health training for hospital staff.

Patient experience

We note that the Trust is committed to providing the best possible patient experience and is always looking for ways to improve that experience for both inpatients and outpatients. This area has always been a priority and it is essential that patients, carers and members of the public are treated as equal partners and have confidence that their feedback is listened to and has led to improved services. We commend action by the Trust to form partnership working initiatives to bring staff and users together and to monitor the effectiveness of these initiatives.

Right care, right time, right place

This captures one of the Trust's key initiatives that focuses on ensuring patients receive the best possible care, in the most appropriate place and at the right time. This alongside a drive to improve discharge arrangements, end of life care measures, and in personalised care planning. We commend action to strengthen collaborative working across the health and social care system to deliver sustainable improvements in care. Key to these improvements is to equip staff with the necessary skills and experience to cope with the heavy demands and pressures placed upon them.

Staff Retention and Wellbeing

We commend proposed action by the Trust to support, encourage and develop staff – whether new or existing staff. With workforce supply an ongoing challenge,

it is important that the health, safety and wellbeing of staff is given a high priority and that all is done to encourage their retention.

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.

Governors Report

A large organisation depends entirely on its people. How every individual member is motivated to do their job even better than before is crucial, and the performance of the staff at MPH during a year of increasing demand has been quite exceptional. At every level staff have gone above and beyond what is normally expected of them and this level of performance and commitment has been widely commented on by patients, carers and visitors.

Having said this, of course governors are acutely aware of the difficulty of recruiting and retaining high calibre staff in all areas of the hospital. Quite rightly the report emphasises the challenge of overcoming retention problems which are national and departmental. The reputation of the hospital, both nationally and locally, will be a huge benefit in this area.

Governors have been emphasising the importance of staff training for mental health patients in all departments and it is therefore excellent to see the importance placed on this over the coming year. Although this training would normally be expected to concentrate on adults and the elderly, it is absolutely vital that the mental health of the under 18 group of patients should be included at every level. The closer cooperation between Musgrove Park Hospital (Taunton and Somerset NHS Foundation Trust) and Somerset Partnership NHS Foundation Trust will definitely help with this and governors look forward to seeing how the Psychiatric Liaison Team begin their important work.

The alliance with Somerset Partnership NHS Foundation Trust has also facilitated joint working to improve the patient journey in key areas, particularly the excellent work to reduce delayed transfers of care such as the Home First initiative. The Governors' Patient Care Group continues to monitor a number of projects relating to improving discharge, promoting independence of patients and tackling complex end of life care issues. The Group has had regular updates from the Older Persons Assessment and Liaison OPAL service, the Joint Emergency Therapy Team (JETT) and the End of Life Care team, all of which are rightly highlighted in the Quality Account.

The Integrated Front Door is another excellent example of the way in which the hospital is working to make the patient pathway much smoother, starting from the Emergency Department and then filtering through into other departments. Governors are keen to watch how this progresses throughout the year and anticipate considerable improvement in the experience of many patients.

In addition to these exciting developments, the Patient Care Group also monitors key metrics that demonstrate the safety of care. As detailed in the Quality Accounts, safety priorities include falls, pressure ulcers, infection control and sepsis; these are all areas that the Group has discussed in detail, offering supportive challenge and trying to get a greater understanding of the issues where we can.

Patient Care Group
17/05/2018

Annex 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 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 NHS 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 and supporting guidance.

- 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 04/05/2018

    - Feedback from governors dated 17/05/2018

    - Feedback from Local Healthwatch organisations dated 02/05/2018

    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS complaints Regulations 2009, dated 23/05/2017

    - The 2016 national patient survey report dated 31/05/2017

    - The 2017 national staff survey report dated 06/03/2018

    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 24/05/2018

    - The Care Quality Commission (CQC) report dated 05/12/2017

- The Quality Report presents a balanced picture of the Taunton and Somerset 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 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 that they have complied with the above requirements in preparing the Quality Report.

By order of the Board.
NB: sign and date in any colour ink except black

24/05/2018 Date…….Chairman
COLIN DRUMMOND

24/05/2018 Date……Chief Executive
PETER LEWIS

Independent Auditors' Limited Assurance Report to the Council of Governors of Taunton and Somerset NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Taunton and Somerset NHS Foundation Trust to perform an independent assurance engagement in respect of Taunton and Somerset NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria***
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	Page 130 of the Quality Report
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Page 130 of the Quality Report

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 specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2017/18" issued by Monitor (operating as NHS Improvement) ("NHSI").

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 does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the sources specified below; and

- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and 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 FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; 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 the following documents:

- Board minutes for the financial year, April 2017 and up to 24 May 2018 (the period);
- Papers relating to quality report reported to the Board over the period April 2017 to the date of signing this limited assurance report;
- Feedback from the Commissioners dated 4 May 2018;
- Feedback from Governors dated 17 May 2018;
- Feedback from Local Healthwatch organisations dated 2 May 2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23 May 2018;
- The 2016 national and local patient survey dated 31 May 2017;
- The 2017 national and local staff survey dated 6 March 2018;
- Care Quality Commission inspection, dated 5 December 2017; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 24 May 2018.

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.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Taunton and Somerset NHS Foundation Trust as a body, to assist

the Council of Governors in reporting Taunton and Somerset 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 indicators. 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 Taunton and Somerset NHS Foundation Trust for our work or this report save 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 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less 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.

result in materially different measurements and can impact 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 thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2017/18"and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trust.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Taunton and Somerset 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 does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Bristol
24 May 2018

The maintenance and integrity of the Taunton and Somerset NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Taunton and Somerset NHS
NHS Foundation Trust

Annual accounts for the year ended 31 March 2018

Taunton and Somerset NHS
NHS Foundation Trust

Annual accounts for the year ended 31 March 2018

INDEX

Foreword to the accounts

Taunton & Somerset NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Taunton & Somerset NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

The Taunton and Somerset NHS Foundation Trust annual report and accounts are presented to Parliament pursuant to schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

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

Signed .....

Name **Peter Lewis**
Job title **Chief Executive**
Date **24 May 2018**

Independent auditors' report to the Council of Governors of Taunton and Somerset NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Taunton and Somerset NHS Foundation Trust's (the "Trust") 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 and cash flows for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Accounts and Quality Account 2017/18 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2018; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1 to the financial statements concerning the Trust's ability to continue as a going concern.

The Trust is forecasting a deficit of £11.2 million for 2018/19. The forecast deficit for 2018/19 is also based on a number of assumptions, including the delivery of cost savings. The Trust's forecast cash position as at 31 March 2019 is dependent on a working capital facility from the Department of Health and Social Care. The extent and nature of the funding and capital funding, including whether such support will be forthcoming or sufficient, is currently uncertain, as are any terms and conditions associated with the funding. This is on account of the set-up of the interim funding regime.

These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Details of material uncertainty

See note 1 to the financial statements for the directors' disclosures of the going concern basis of preparation, and rationale for using this basis.

We focused on this area in particular due to the deterioration in the Trust's financial position and the uncertainty over the Trust's ability to continue as a going concern. The Trust continues to experience increases in demand for services that are outstripping increases in funding and cost savings being achieved.

The Department of Health and Social Care Group Accounting Manual 2017/18 requires that the financial statement should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of a NHS foundation Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

The Trust's current year deficit is £5.0 million which was behind its originally planned control target. The Trust is forecasting a deficit for 2018/19. The extent, nature and availably of any financial support to meet funding requirements, which includes a working capital facility from the Department of Health and Social Care, has not yet been confirmed.

Work we performed on going concern

In considering the financial performance of the Trust and the appropriateness of the going concern assumption in the preparation of the financial statements, we obtained the 2018/19 annual plan and:

- examined the impact of cash flow sensitivities and assessed these against the Trust's ability to meet its liabilities as they fall due;
- sensitised the assumptions behind the Trust's financial forecasts by comparing them to historical performance against plan; and
- obtained a list of material balances owed to and from other health bodies through the national agreement of balances exercise at 31 March 2018 and assessed the impact differences would have on the working capital assumptions within the cash flow forecast.

The Trust secured an interim loan with the Department of Health and Social Care in March 2018. However, the forecasts suggest that further funding will be required for the Trust to meet its liabilities from quarter two of 2018/19.

The Trust will negotiate additional loan funding in quarter three of 2018/19 to cover the financial requirements for the rest of 2018/19. These negotiations will be started later in the 2018/19 financial year (at least two months prior to the loan being required). The Trust will also assess the need for further funding for 2019/20 when negotiating its control total.

Our audit approach

Context

Our audit for the year ended 31 March 2018 was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged apart from an ongoing focus on the Trust's financial sustainability.

The Trust did not meet its control total for the year ended 31 March 2018. This meant the Trust was not eligible to receive Sustainability and Transformation Funding. As a result, the Trust has had additional cash support in the form of interim revenue loan support from the Department of Health and Social Care.

Overview

- Overall materiality: £6.1 million which represents 2% of total revenue.

- In establishing our overall approach we assessed the risks of material misstatement and applied our professional judgement to determine the extent of testing required over each balance in the financial statements.
- We performed our audit of the financial information for the Trust at Musgrove Park Hospital.
- The Trust includes the Trust and its interests in three joint arrangements, Southwest Pathology Services LLP, Southwest Path Services LLP and SPS Facilities LLP.

- Going concern;
- Risk of fraud in revenue and expenditure recognition; and
- Valuation of the Trust's land and buildings (including dwellings).

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

We gained an understanding of the legal and regulatory framework applicable to the group and the industry in which it operates, and considered the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud. We designed audit procedures at group and significant component level to respond to the risk, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. We focused on laws and regulations that could give rise to a material misstatement in the Trust's financial statements, including, but not limited to, the National Health Service Act 2006, UK tax legislation and equivalent local laws and

regulations applicable to significant component teams. Our tests included, but were not limited to review of the financial statement disclosures to underlying supporting documentation, review of correspondence with the regulators, review of correspondence with legal advisors, enquiries of management, and review of internal audit reports in so far as they related to the financial statements. There are inherent limitations in the audit procedures described above and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we would become aware of it.

We did not identify any key audit matters relating to irregularities, including fraud. As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, 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. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to financial sustainability and going concern, described in the Material Uncertainty relating to going concern section above, we determined the matters described below to be the key audit matters to be communicated in our report. This is not a complete list of all risks identified by our audit.

Key audit matter	*How our audit addressed the Key audit matter*
Risk of fraud in revenue and expenditure recognition *See note 1 to the financial statements for the directors' disclosures of the related accounting policies for revenue and expenditure recognition and notes 3 to 5 for further information.* Under ISAs (UK) 240 there is a (rebuttable) presumption that there are risks of fraud in revenue recognition. We extend this presumption to the recognition of expenditure in the NHS in general. With continuing pressures and challenges to meet the control totals and qualify for sustainability transformation funding (STF), there is a risk that revenue could be fraudulently overstated and expenditure understated by being posted into the incorrect period. The main source of revenue for the Trust is from contracts with commissioning bodies in respect to healthcare services, under which revenue is recognised when, and to the extent that, healthcare services are provided to patients. Significant other operating income for the Trust includes education and training, services provided to other NHS bodies, and sustainability and transformation fund ("STF") revenue. For revenue, we focused on this area because there is a heightened risk due to: • the Trust being under increasing financial pressure. It is set a control total for the financial year, with STF revenue paid when certain financial and non-financial targets are met. Whilst the Trust is looking at ways to maximise revenue, there is an incentive for the Trust to recognise as much revenue as possible in 2017/18 to meet its control total; • the operating position of the Trust and the further risk that the directors may incorrectly recognise revenue through fictitious journal entries; and • how there may not be a underlying agreement or contract for the recognising correctly other operating income. For expenditure, we focused on this area because there is a heightened risk due to: • the Trust being under increasing financial pressure. Whilst the Trust is looking at ways to reduce expenditure, there is an incentive for the Trust to defer expenditure to 2018/19 in order to meet its control total. We considered the key areas of focus to be: • recognition of revenue and expenditure; and • manipulation of journal postings to the general ledgers.	We evaluated and tested the application of the accounting policy for revenue and expenditure recognition to ensure that this is consistent with the requirements of the Department of Health and Social Care Group Accounting Manual 2017/18. Where revenue or expenditure was recorded through journal entries, we traced the journal to patient records or invoices on a sample basis to establish whether a service had been provided or a sale occurred. We did not identify any transactions that were indicative of fraud in the recognition of revenue or expenditure. We tested patient activity revenue by agreeing the amounts recognised in the revenue statements to contracts and to the Trust's patient activity system to ensure that amounts were contractually due, reflected actual activity and to confirm when the activity occurred. We also tested the IT controls over the Trust's patient activity system. We tested a sample of other revenue by tracing the transaction to invoices or other correspondence, and using our knowledge and experience in the sector, to determine whether the revenue was recognised in the correct period. Items of other revenue included private patient revenue, overseas patient revenue, education and training and research and development. Similarly, for expenditure, we selected a number of payments made by agreeing them to the supplier invoices received to ensure they were recognised at the correct value and in the correct period. Furthermore, we performed testing on a sample basis, to agree payments made and invoices received after the year end to supporting documentation and checking that, where they related to 2017/18 expenditure, an accrual was recognised appropriately. In addition we completed testing on a risk based approach across the general ledger. We used data analysis techniques to identify the journals that had higher risk characteristics. We agreed the journals posted to supporting by documentation such as invoices, contracts and other records consistent with that documentation and recognised in the correct accounting period.

Valuation of the Trust's land and buildings (including dwellings)

See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates and note 14 for further information.

The Trust is required to regularly revalue its assets in line with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have focused on this area due to the material nature of this balance, and the consequent impact on the financial statements were it to be materially misstated.

As at the balance sheet date 31 March 2018, the Trust's land and buildings (including dwellings) are valued at £141.5 million (2017: £132.7 million). The financial statements show a net revaluation of £9.4 million through the Statement of Changes in Equity (2017: £6.3 million).

All property, plant and equipment is measured initially at cost, with land and buildings (including dwellings) subsequently measured at fair value.

Valuations are performed by a professionally accredited expert, in accordance with the Royal Institute of Chartered Surveyors ("RICS") Appraisal and Valuation Manual, and performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the balance sheet date.

The specific areas of risk are:

- accuracy and completeness of detailed information on assets provided to the valuation expert – most significantly the floor plans, on which the valuation of hospital properties is routinely based;
- the methodology, assumptions and underlying data used by the valuation expert; and
- the accounting transactions resulting from this valuation.

We obtained and read the relevant sections of the valuation performed by the Trust's valuers. We used our own valuations expertise to evaluate and compare the assumptions and methodology applied in the valuation exercise to industry benchmarks.

We checked that the valuer had a UK qualification, was part of an appropriate professional body and was independent of the Trust.

We considered, based on our knowledge of the Trust obtained during our audit, whether the Trust had any future plans that would impact on the usage (and, hence, valuations) of the properties.

We tested the underlying data (upon which the valuation was based) back to floor plans for a sample of properties.

We checked that the change in valuation was disclosed in the Annual Report and correctly reflected in the Trust's workings and the general ledger. This we did by testing a sample of asset values which had increased or decreased by checking the Trust had posted the journals to account for the valuation correctly, and found that, for all assets tested, the revaluation had been posted accordingly in the general ledger.

We physically verified a sample of assets to confirm existence and in doing so considered whether there was any indication of physical obsolescence which would indicate potential impairment; our testing did not identify any significant matters.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the accounting processes and controls, and the environment in which the Trust operates.

The Trust comprises a single entity with all books and records retained at the finance team in Musgrove Park Hospital. We conducted our audit at the headquarters. We focussed our work on the areas of focus described above.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£6.1 million (2017: £5.9 million)
How we determined it	2% of total revenue (2017: 2% of total revenues)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £300,000 (2017: £250,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 28, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for 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 the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

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 an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

As part of an audit in accordance with ISAs (UK), we exercise professional judgement and maintain professional scepticism

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has 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. Based our on risk assessment, we undertook such work as we considered necessary.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Taunton and Somerset NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006

and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

We draw your attention to the Trust's Annual Governance Statement on page 74 of the Annual Report which includes further details on the matters noted below and the Trust's actions to address the issues.

The Trust reported a deficit of £5.0 million in 2017/18 and did not meet its control total. Under the Single Operating Framework the Trust's rating was reduced to 4 at the year-end. The Trust has submitted its 2018/19 annual plan which reports a planned deficit. The control total for the Somerset health system has not been agreed. Consequently the Trust has not received agreement of the level of Provider Sustainability Funds. The planned deficit includes a target level of cost savings which have not all been formally identified.

Qualified conclusion

Except for the matters noted above, we have no other matters to report in relation to proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Other matters on which we report by exception

We are required to report to you if:

- the statement given by the directors on page 34, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for members to assess the Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual report on page 35, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- we have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Heather Ancient

Heather Ancient (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Bristol
24 May 2018

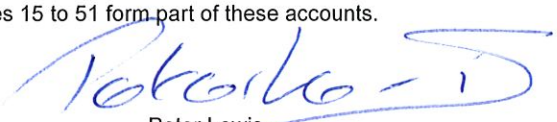
Statement of Comprehensive Income for the Year Ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	268,339	259,428
Other operating income	4	40,560	40,442
Operating expenses	5, 7	(308,164)	(298,381)
Operating surplus from continuing operations		**735**	**1,489**
Finance income	10	30	26
Finance expenses	11	(1,726)	(1,843)
PDC dividends payable		(3,967)	(3,942)
Net finance costs		**(5,663)**	**(5,759)**
Other losses	12	(177)	(15)
Share of profit of joint arrangements	15	90	31
Deficit for the year from continuing operations		**(5,015)**	**(4,254)**
Deficit for the year		**(5,015)**	**(4,254)**
Other comprehensive income/(expense)			
Will not be reclassified to income and expenditure:			
Impairments	6	-	(660)
Revaluations	14	9,360	6,972
Total comprehensive income for the year		**4,345**	**2,058**

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	11,418	9,066
Property, plant and equipment	14	169,967	161,642
Investments in associates and joint ventures	15	104	117
Trade and other receivables	18	1,301	1,180
Total non-current assets		**182,790**	**172,005**
Current assets			
Inventories	17	3,635	3,769
Trade and other receivables	18	12,436	11,285
Cash and cash equivalents	20	4,905	8,027
Total current assets		**20,976**	**23,081**
Current liabilities			
Trade and other payables	21	(28,234)	(25,812)
Borrowings	23	(1,975)	(2,165)
Provisions	25	(114)	(122)
Other liabilities	22	(2,808)	(3,174)
Total current liabilities		**(33,131)**	**(31,273)**
Total assets less current liabilities		**170,635**	**163,813**
Non-current liabilities			
Trade and other payables	21	(539)	(524)
Borrowings	23	(26,861)	(28,439)
Provisions	25	(832)	(848)
Other liabilities	22	(3,235)	(3,494)
Total non-current liabilities		**(31,467)**	**(33,305)**
Total assets employed		**139,168**	**130,508**
Financed by			
Public dividend capital		82,697	78,382
Revaluation reserve		54,724	45,765
Income and expenditure reserve		1,747	6,361
Total taxpayers' equity		**139,168**	**130,508**

The notes on pages 15 to 51 form part of these accounts.



Name Peter Lewis
Position Chief Executive
Date **24 May 2018**

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Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers Equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**78,382**	**45,765**	**6,361**	**130,508**
Surplus/(deficit) for the year	-	-	(5,015)	**(5,015)**
Revaluations	-	9,360	-	**9,360**
Transfer to retained earnings on disposal of assets	-	(401)	401	**-**
Public dividend capital received	4,315	-	-	**4,315**
Taxpayers' equity at 31 March 2018 - carried forward	**82,697**	**54,724**	**1,747**	**139,168**

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers Equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**78,382**	**39,453**	**10,615**	**128,450**
Surplus/(deficit) for the year	-	-	(4,254)	**(4,254)**
Impairments	-	(660)	-	**(660)**
Revaluations	-	6,972	-	**6,972**
Taxpayers' equity at 31 March 2017 - carried forward	**78,382**	**45,765**	**6,361**	**130,508**

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Information on reserves

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

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

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

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Statement of Cash Flows for the Year Ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus		735	1,489
Non-cash income and expense:			
Depreciation and amortisation	5.1	8,754	8,833
Net impairments	6	1,981	5,033
Income recognised in respect of capital donations	4	(964)	(616)
Amortisation of PFI deferred credit		(259)	(259)
Increase in receivables and other assets		(1,271)	(524)
Decrease in inventories		134	121
Increase / (decrease) in payables and other liabilties		34	(807)
Increase / (decrease) in provisions		(63)	53
Other movements in operating cash flows		-	36
Net cash generated from operating activities		**9,081**	**13,359**
Cash flows from investing activities			
Interest received		30	26
Purchase of intangible assets		(3,681)	(1,831)
Purchase of property, plant, equipment and investment property		(7,063)	(4,492)
Sales of property, plant, equipment and investment property		1,020	225
Receipt of cash donations to purchase capital assets		964	616
Net cash used in investing activities		**(8,730)**	**(5,456)**
Cash flows from financing activities			
Public dividend capital received		4,315	-
Movement on loans from the Department of Health and Social Care		(648)	3,768
Capital element of finance lease rental payments		(567)	(524)
Capital element of PFI, LIFT and other service concession payments		(1,026)	(775)
Interest paid on finance lease liabilities		(394)	(436)
Interest paid on PFI, LIFT and other service concession obligations		(1,019)	(1,071)
Other interest paid		(274)	(348)
PDC dividend paid		(3,963)	(4,058)
Cash flows generated from other financing activities		103	-
Net cash used in financing activities		**(3,473)**	**(3,444)**
Increase / (decrease) in cash and cash equivalents		**(3,122)**	**4,459**
Cash and cash equivalents at 1 April - brought forward		**8,027**	**3,568**
Cash and cash equivalents at 31 March - carried forward	20	**4,905**	**8,027**

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Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the accounts 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 accounts 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

These accounts have been prepared on a going concern basis.

The Trust has reported a deficit for 2017/18 and is forecasting a deficit for 2018/19. The forecast deficit is based on a number of assumptions including the delivery of cost improvement programmes. The Trust has assumed it will receive financial support from the Department of Health and Social Care during the course of 2018/19 in order to meet its liabilities and continue to provide healthcare services. The extent and nature of the financial support from the Department of Health and Social Care, including whether such support will be forthcoming or sufficient, is currently uncertain, as are any terms and conditions associated with the funding. The existence of such material uncertainty may cast doubt about the Trust's ability to continue as a going concern. The Trust will apply for cash support in line with current NHS funding policy.

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts. The expectation is informed by the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in the published documents. Contracts for Service, being the NHS Standard Contract 2018/19 has been signed with the Trust's main commissioners.

The accounts do not include any adjustments that would result if the Foundation Trust was unable to continue as a going concern.

Note 1.2 Interests in other entities

Joint Ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. IFRS 11 specifies that since the Trust does not have subsidiaries that are consolidated and does not therefore produce consolidated accounts, the Trust is required to prepare 'economic interest' accounts in which interests in joint ventures are accounted for using the equity method.

Note 1.3 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. At the year end, the Trust accrues income relating to activity delivered in that year and where a patient care spell is incomplete.

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.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the 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 expense is also recognised at the point of recognition for the benefit.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 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.

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Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- it forms part of the initial equipping and setting-up costs of a new building or refurbishment of a 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, eg, fabric and engineering, then these components are treated as separate assets and depreciated over their different useful economic lives.

Note 1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value. The frequency of the revaluations is dependent on the changes in the fair value of the items of property, plant and equipment being revalued. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Property assets

The fair value of land and buildings is determined by valuations carried out by the Trust's valuer GVA. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual and are carried out primarily on the basis of Depreciated Replacement Cost (DRC) which is measured on a Modern Equivalent Asset basis for specialised operational property. Non-specialised operational property is measured on an Existing Use Value.

A full valuation (excluding assets under construction/work in progress) was undertaken as at 1 April 2016. A subsequent desktop valuation has been carried out for 31 March 2018. This value, together with indexation applied to buildings in line with the Valuers advice has been included in the closing Statement of Financial Position.

The component elements of each property asset are depreciated individually where the value of the component parts are judged to be material in relation to the overall value of that asset and where the useful economic lives of the components are significantly different from that of the overall property asset. The component parts that are individually depreciated by the Trust are building structures, engineering elements and external works.

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. GVA have supplied amended estimates of the diminution in value relating to operational buildings scheduled for imminent closure and subsequent demolition. These buildings have been written down in the accounts to these values. Open market values have also been provided for land and residences.

Assets under construction are valued at cost and are subsequently revalued by professional valuers if, when brought into use, factors indicate that the value of the asset differs materially from its carrying value. Otherwise, the asset should only be re-valued on the next occasion when all assets of that class are re-valued. Work in progress is assessed at the financial year end on the basis of identified work completed that has been certified as such by Trust staff or advisors. Payments on account for work not yet undertaken are accounted for as prepayments.

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.

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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.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses.

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.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of operating expenses.

Impairments
In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once 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 ie:
-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 are to be scrapped or demolished do not qualify for recognition as 'held for sale' and instead retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.3 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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Note 1.6.4 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Note 1.6.5 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	4	90
Dwellings	36	40
Plant & machinery	5	25
Transport equipment	5	10
Information technology	5	8
Furniture & fittings	4	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 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 Trust and where the cost of the asset can be measured reliably.

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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, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- 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, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset. Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred and these are amortised over the shorter of the term of the licence and their useful lives.

Note 1.7.2 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. Revaluations 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 at fair value 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.

Note 1.7.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Software licences	8	10

Note 1.8 Inventories
Inventories are valued at the lower of cost and net realisable value. Due to the high turnover of stocks within the Trust, current costs are used as a fair estimate of first in/ first out valuation.

Note 1.9 Cash and Cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 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, ie, 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 above/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.

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.

Other financial liabilities
All other 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.

Determination of fair value
For financial assets carried at fair value, the carrying amounts are determined from independent valuations.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" 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 bad debt provision.

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Note 1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.11.1 The Trust as lessee

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 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 asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for 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 de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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.

Note 1.11.2 The Trust as lessor

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, 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 and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.15 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.16 Corporation tax
The Trust is a Health Service Body within the meaning of s986 Corporation Taxes Act 2010. Accordingly it is not liable to corporation tax. The Trust is also exempt from tax on chargeable gains under s271(3) Taxation of Chargeable Gains Act 1992.
There is, however, a power for HM Treasury to submit an order to Parliament which will dis-apply the corporation tax exemption in relation to particular activities of an NHS Foundation Trust (s987 Corporation Taxes Act 2010). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities to be specified in the order which are not related to, or ancillary to, the provision of healthcare, and where the profits therefrom exceed £50,000 per annum. Until such an order is approved by Parliament, the Trust has no corporation tax liability.

Note 1.17 Foreign exchange
The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.22 Critical Accounting estimates and judgements
International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of evaluation is to consider whether there may be a significant risk of causing material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these accounts.

Value of land, buildings and dwellings £142 million (2016-17 £133m): This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty. Note 1.16.2 gives details of the valuation methods used in these accounts. Note 6 and Note 14.4 give details of Imapirment and Revaluation movements.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted
The Treasury FReM does not require the following standards and interpretations to be applied in 2017/18.

IFRS 9 Financial Instruments, effective date 1 January 2018
IFRS15 Revenue from Contracts with Customers, effective date 1 January 2018
IFRS 16 Leases, effective date 1 January 2019

The Trust is going through a process of accessing the potential impact of these standards and will refer to and follow any Department of Health and Social Care guidance as and when issued.

The Trust assessment is that the impact of IFRS 9 will be minimal.
IFRS 15 will require the Trust to review contracts with its Commissioners and agree when income should be recognised. The impact is not expected to be material but may change the current treatment of maternity pathway income.

IFRS 16 will require a review of all contracts that contain a lease (except those identified as a PFI or service concession) and bring them on balance sheet as a "right to use" asset. This standard is currently subject to on-going consultation within HM Treasury and is not expected to have a material impact on the accounts overall.

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Note 2 Operating Segments

Operating segments are reported in a manner consistent with the internal reporting provided to the Chief Operating Decision Maker. The Chief Operating Decision Maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the board that makes strategic decisions. The Taunton and Somerset NHS Foundation Trust is managed by the Board of Directors, which is made up of both Executive and Non-Executive Directors. The Board is responsible for strategically and operationally leading the work of the hospital. The Non-Executive Directors bring external expertise to the organisation and provide advice and guidance to the Executive Directors. The Executive Directors take care of the day to day running of the hospital.

The Board is therefore considered to be the Chief Operating Decision Maker (CODM) of the hospital.

The monthly financial information presented to the Board includes a trust level Statement of Comprehensive Income, a Statement of Financial Position, a Statement of Cash flows and other financial indicators such as the continuity of service risk rating. For the majority of the year, the segmental expenditure data is included in the overall performance report by way of a separate note which summarises the contributions of the directorates, and separately identifies reserves and central budgets. The detail includes current period and year to date data, in each case comparing actual data to plan. The commentary also includes the Directorates' contribution to trust wide initiatives, such as cost improvement programmes. Other information reported to the Board is specifically analysed for its purpose, for example trust pay spend against budget analysed by employee groups and income stream expectations by type (NHS Clinical, non NHS etc) compared to actual achieved. Information such as delivery of the savings plan is a trust wide position paper but detailed into the areas tasked with implementing savings.

The Trust has used three key factors in its identification of its reportable operating segments. The key factors are that the reportable operating segment:

a) engages in activities from which it earns revenues and incurs expenses;

b) reports financial results which are regularly reviewed by the Trust's board of directors to make decisions about allocation of resources to the segment and to assess its performance; and

c) has discrete financial information.

The Trust's reportable segments and services provided are:

Acute Medicine

The services provided by this operating segment include A&E, Cardiology, Care of the Elderly, Endocrinology, Neurology, Rehabilitation, Respiratory and Stroke.

Surgery and Critical Care

The services provided by this operating segment include Gastroenterology, Upper and Lower GI Surgery, Nephrology, Vascular, Breast Care Centre, Dermatology, Genitourinary Medicine (GUM), Urology, Orthopaedics, Rheumatology, Theatres, ITU/HDU, Anaesthetics, Sterile Services, Pre-op Assessment, Surgical Admissions and Pain Services.

HOPE and Clinical Support

The services provided by this operating segment include the dedicated cancer centre, Haematology & Oncology, Pharmacy, Therapies, Pathology, Imaging and other diagnostic testing. It is responsible for the management of the Trusts Clinical Trials/Research Unit.

Corporate

This segment provides corporate management for the Trust and includes the administrative aspects of governance and professional management of all clinical staff, the Trust Board, Finance, Information and IT, Organisational Development, Performance Development, Operational Management and Education and Training.

Women & Children

The services provided by this operating segment include Reproductive Medicine, EPAC, Gynaecology, Maternity and Paediatrics (including SNICU).

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Note 2.1 Operating Segments

For the year ended 31 March 2018

	ACUTE MEDICINE	HOPE - CLINICAL SUPPORT	CORPORATE	OPERATIONAL MANAGEMENT	SURGERY AND CRITICAL CARE	WOMEN AND CHILDREN	Total
	£000	£000	£000	£000	£000	£000	£000
Income	76,140	50,108	20,159	2,021	106,952	37,209	292,589
Non pay	(13,195)	(41,472)	(39,941)	(1,714)	(26,174)	(3,542)	(126,038)
Pay	(45,911)	(27,145)	(26,360)	(3,182)	(57,169)	(20,421)	(180,188)
Grand Total	17,034	(18,509)	(46,142)	(2,875)	23,609	13,246	(13,637)

Reconciliation to Statement of Comprehensive Income	
Education Income	14,643
Research & Development Income	1,666
PDC Dividend	(3,967)
Fixed Asset Impairment	(1,981)
Net Interest Receivable	5
Other Adjustments:	
Total Interest Payable On Loans And Leases	(279)
Interest Expense on non-PFI Finance Leases	(372)
Interest Expense on PFI Finance Leases	(1,019)
Dividends Receivable - Joint Venture And Associates	103
Loss On Asset Disposals	(177)
Net Deficit	(5,015)

For the year ended 31 March 2017

	ACUTE MEDICINE	HOPE - CLINICAL SUPPORT	CORPORATE	OPERATIONAL MANAGEMENT	SURGERY AND CRITICAL CARE	WOMEN AND CHILDREN	Total
	£000	£000	£000	£000	£000	£000	£000
Income	71,144	47,285	17,515	1,443	108,291	35,039	280,717
Non pay	(13,190)	(38,891)	(32,331)	(1,448)	(25,807)	(3,541)	(115,208)
Pay	(43,027)	(26,069)	(24,981)	(1,670)	(56,297)	(19,806)	(171,850)
Grand Total	14,927	(17,675)	(39,797)	(1,675)	26,187	11,692	(6,341)

Reconciliation to Statement of Comprehensive Income	
Education Income	9,743
Research & Development Income	1,654
PDC Dividend	(3,942)
Fixed Asset Impairment	(5,033)
Net Interest Receivable	(50)
Other Adjustments:	
Total Interest Payable On Loans And Leases	(346)
Interest Expense on non-PFI Finance Leases	(415)
Interest Expense on PFI Finance Leases	(1,071)
STF Incentive and Bonus Funding	1,432
Dividends Receivable - Joint Venture And Associates	85
Profit On Asset Disposals	30
Net Deficit	(4,254)

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Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	41,936	45,064
Non elective income	84,751	72,797
First outpatient income	20,853	19,504
Follow up outpatient income	22,218	23,236
A & E income	9,709	7,692
High cost drugs income from commissioners (excluding pass-through costs)	29,245	27,495
Other NHS clinical income	54,436	60,367
All services		
Private patient income	2,421	2,387
Other clinical income	2,770	886
Total income from activities	**268,339**	**259,428**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	54,861	54,727
Clinical commissioning groups	208,287	201,248
Other NHS providers	106	183
NHS other	335	164
Local authorities	-	23
Non-NHS: private patients	2,421	2,397
NHS injury scheme	870	537
Non NHS: other	1,459	149
Total income from activities	**268,339**	**259,428**
Of which:		
Related to continuing operations	268,339	259,428

NHS Injury Scheme income is subject to a provision for doubtful debts of 22.84% (22.94% in 2016/17) to reflect expected rates of collection.

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Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	-	-

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	1,666	1,654
Education and training *	14,643	15,930
Receipt of capital grants and donations	964	616
Non-patient care services to other bodies **	14,083	11,082
Sustainability and transformation fund income	6,712	8,838
Rental revenue from operating leases	273	271
Income in respect of staff costs where accounted on gross basis	520	375
Other income	1,699	1,676
Total other operating income	**40,560**	**40,442**
Of which:		
Related to continuing operations	40,560	40,442

*Comparative figures have been amended to show gross the income and pay costs associated with the payroll costs of psychology students studying around the South West of England. The income from Health Education England fully matches the associated pay costs (shown in note 5.1 - staff and executive Director costs) and the restatement reflects the treatment of the costs in the accounts of Health Education England. The income was £6,122,000 in 2017/18 (£6,187,000 in 16/17).

** Non patient care services to other bodies includes income for Pharmacy, Estates, HR and IT services provided to other NHS bodies.

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	263,148	256,155
Income from services not designated as commissioner requested services	45,751	43,715
Total	**308,899**	**299,870**

Note 4.2 Profits and losses on disposal of property, plant and equipment

The Trust disposed of a range of radiology equipment to the provider of the radiology managed facility service for a receipt of £992,000 against a net book value of £1,130,000 leaving a loss on sale of £138,000. In addition a CT scanner was disposed of for £28,000 against a net book value of £58,000 leaving a loss on sale of £30,000. One item of equipment with value of £9,000 was written-off during the year.

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Note 5.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,875	2,778
Purchase of healthcare from non-NHS and non-DHSC bodies	14,575	13,510
Purchase of social care	-	-
Staff and executive directors costs**	186,074	177,457
Remuneration of non-executive directors	141	149
Supplies and services - clinical	25,482	27,209
Supplies and services - general	3,329	3,116
Drug costs	32,354	30,468
Consultancy costs	237	561
Establishment	1,694	1,596
Premises	10,310	9,442
Transport (including patient travel)	1,149	1,321
Depreciation on property, plant and equipment	7,417	7,635
Amortisation on intangible assets	1,337	1,198
Net impairments	1,981	5,033
Increase/(decrease) in provision for impairment of receivables	46	149
Change in provisions discount rate(s)	9	76
Audit fees payable to the external auditor		
audit services- statutory audit	85	80
other auditor remuneration (external auditor only)	2	992
Internal audit costs	96	136
Clinical negligence	10,738	9,762
Legal fees	388	265
Insurance	229	269
Research and development	87	114
Education and training	970	731
Rentals under operating leases	540	524
Redundancy	96	431
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	2,822	1,715
Hospitality	40	34
Losses, ex gratia & special payments	33	27
Other services, eg external payroll	424	553
Other*	2,604	1,050
Total	**308,164**	**298,381**
Of which:		
Related to continuing operations	308,164	298,381
Related to discontinued operations	-	-

*Other expenditure includes a Somerset Sustainability and Transformation Plan risk share cost of £1,003k and Professional fees of £384k

**Comparative figures have been amended to show gross the income and pay costs associated with the payroll costs of psychology students studying around the South West of England. The income from Health Education England fully matches the associated pay costs (shown in note 5.1 - staff and executive Director costs) and the restatement reflects the treatment of the costs in the accounts of Health Education England. The income was £6,122,000 in 2017/18 (£6,187,000 in 16/17).

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Note 5.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	2	-
6. All assurance services not falling within items 1 to 5	-	8
8. Other non-audit services not falling within items 2 to 7 above	-	984
Total	**2**	**992**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus resulting from:		
Other	1,981	5,033
Total net impairments charged to operating surplus	**1,981**	**5,033**
Impairments charged to the revaluation reserve	-	660
Total net impairments	**1,981**	**5,693**

The Trust's land, buildings and dwellings were revalued by GVA as at 31 March 2018. The Trust's specialised buildings and associated land have been valued using the depreciated replacement cost method, based upon provision of a modern equivalent asset (MEA). A fundamental principle of MEA valuations is that a hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for the existing operations. The valuation of the Trust's specialised land and buildings has therefore been based upon the Trust hypothetically being located on a suitable alternative site away from the town centre, where the cost of the land would be significantly lower, but where the Trust would still be able to re-provide its services. Applying these MEA revaluations has resulted in a net overall increase of £7,379,000 in the value of the Trust's estate. This increase in value of the Trust's estate is recorded in property, plant and equipment. £(1,981,000) has been recognised as a net impairment charged to the Statement of Comprehensive Income and the remaining £9,360,000 has been recognised as an increase to the revaluation reserve.

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Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	147,461	140,265
Social security costs	13,394	13,498
Apprenticeship levy	704	-
Employer's contributions to NHS pensions	17,768	16,909
Pension cost - other	-	7
Termination benefits	96	431
Temporary staff (including agency)	8,793	7,846
Total gross staff costs	**188,216**	**178,956**
Recoveries in respect of seconded staff	**(520)**	(375)
Total staff costs	**187,696**	**178,581**
Of which		
Costs capitalised as part of assets	1,525	693

Note 7.1 Retirements due to ill-health

During 2017/18 there was 1 early retirement from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £40,000 (£4,000 in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2017/18 £000	2016/17 £000
Salary	977	986
Employer's National Insurance contributions	128	118
Employer's pension contributions	127	113
Total	**1,232**	**1,217**

Further details of directors' remuneration can be found in the remuneration report.

Benefits are accruing under the NHS defined benefit pension scheme to 9 of the Directors (2016/17: 6). No benefits are accruing under any money purchase schemes.

There were no other advances or guarantees existing with any of the Directors as at 31 March 2018 (2016/17: Nil).

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Note 8 Pension costs

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 year.

In order that the defined benefit obligations recognised in the accounts 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 year. This utilises an actuarial assessment for the previous accounting year in conjunction with updated membership and financial data for the current reporting year 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.

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.

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Note 9 Operating leases

Note 9.1 Taunton & Somerset NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Taunton & Somerset NHS Foundation Trust is the lessor.

Income is generated from catering concessions.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Other	273	271
Total	**273**	**271**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	273	270
- later than one year and not later than five years;	1,092	1,082
- later than five years.	122	395
Total	**1,487**	**1,747**

Note 9.2 Taunton & Somerset NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Taunton & Somerset NHS Foundation Trust is the lessee.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	540	524
Total	**540**	**524**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	425	491
- later than one year and not later than five years;	356	625
- later than five years.	2,486	2,266
Total	**3,267**	**3,382**

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Note 10 Finance income

Finance income represents interest received on assets and investments in the year.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	30	26
Total	**30**	**26**

Note 11.1 Finance expenses

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	296	346
Finance leases	372	415
Main finance costs on PFI and LIFT schemes obligations	1,019	1,071
Total interest expense	**1,687**	**1,832**
Unwinding of discount on provisions	39	11
Total finance costs	**1,726**	**1,843**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-

Note 12 Other losses

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(177)	(15)
Total losses on disposal of assets	**(177)**	**(15)**

The Trust disposed of a range of radiology equipment to the provider of the radiology managed facility service for a receipt of £992,000 against a net book value of £1,130,000 leaving a loss on sale of £138,000. In addition a CT scanner was disposed of for £28,000 against a net book value of £58,000 leaving a loss on sale of £30,000. One item of equipment with value of £9,000 was written-off during the year.

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Note 13.1 Intangible assets - 2017/18

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**11,521**	**1,646**	**13,167**
Additions	78	3,611	**3,689**
Reclassifications	1,922	(1,922)	-
Disposals / derecognition	(18)	-	**(18)**
Gross cost at 31 March 2018	**13,503**	**3,335**	**16,838**
Amortisation at 1 April 2017 - brought forward	**4,101**	-	**4,101**
Provided during the year	1,337	-	**1,337**
Disposals / derecognition	**(18)**	-	**(18)**
Amortisation at 31 March 2018	**5,420**	-	**5,420**
Net book value at 31 March 2018	**8,083**	**3,335**	**11,418**
Net book value at 1 April 2017	**7,420**	**1,646**	**9,066**

Note 13.2 Intangible assets - 2016/17

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**8,426**	**2,925**	**11,351**
Additions	179	1,652	**1,831**
Reclassifications	2,931	(2,931)	-
Disposals / derecognition	(15)	-	**(15)**
Valuation / gross cost at 31 March 2017	**11,521**	**1,646**	**13,167**
Amortisation at 1 April 2016 - as previously stated	**2,918**	-	**2,918**
Provided during the year	**1,198**	-	**1,198**
Disposals / derecognition	(15)	-	**(15)**
Amortisation at 31 March 2017	**4,101**	-	**4,101**
Net book value at 31 March 2017	**7,420**	**1,646**	**9,066**
Net book value at 1 April 2016	**5,508**	**2,925**	**8,433**

Note 14 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
Valuation/gross cost at 1 April 2017 - brought forward	8,156	122,462	2,150	5,841	45,439	110	12,423	5,828	202,409
Additions	-	1,119	1	6,389	1,987	-	32	39	9,567
Impairments	-	(4,534)	(40)	-	-	-	-	-	(4,574)
Reversals of impairments	390	1,443	18	-	-	-	-	-	1,851
Revaluations	-	6,967	169	-	-	-	-	-	7,136
Reclassifications	-	3,215	40	(7,105)	2,684	-	1,123	43	-
Transfers to assets held for sale	-	-	-	-	(1,765)	-	-	-	(1,765)
Disposals / derecognition	-	-	-	(9)	(51)	(29)	(4,951)	(203)	(5,243)
Valuation/gross cost at 31 March 2018	8,546	130,672	2,338	5,116	48,294	81	8,627	5,707	209,381
Accumulated depreciation at 1 April 2017 - brought forward	-	24	-	-	27,606	69	9,767	3,301	40,767
Provided during the year	-	2,876	77	-	3,109	5	1,068	282	7,417
Impairments	-	(103)	(3)	-	-	-	-	-	(106)
Reversals of impairments	-	(632)	(4)	-	-	-	-	-	(636)
Revaluations	-	(2,154)	(70)	-	-	-	-	-	(2,224)
Transfers to assets held for sale	-	-	-	-	(578)	-	-	-	(578)
Disposals / derecognition	-	-	-	-	(46)	(29)	(4,948)	(203)	(5,226)
Accumulated depreciation at 31 March 2018	-	11	-	-	30,091	45	5,887	3,380	39,414
Net book value at 31 March 2018	8,546	130,661	2,338	5,116	18,203	36	2,740	2,327	169,967
Net book value at 1 April 2017 - brought forward	8,156	122,438	2,150	5,841	17,833	41	2,656	2,527	161,642

Note 14.1 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
Valuation / gross cost at 1 April 2016 - as previously stated	9,506	118,364	2,224	5,777	56,888	131	14,776	6,167	213,833
Additions	-	434	-	5,699	274	-	-	31	6,438
Impairments	(1,445)	(6,900)	(132)	-	(2,886)	-	-	-	(11,363)
Reversals of impairments	6	2,768	18	-	-	-	-	-	2,792
Revaluations	149	4,287	200	-	(5,404)	-	-	-	(768)
Reclassifications	-	3,509	-	(5,635)	1,377	-	747	2	-
Transfers to assets held for sale	(60)	-	(160)	-	-	-	-	-	(220)
Disposals / derecognition	-	-	-	-	(4,810)	(21)	(3,100)	(372)	(8,303)
Valuation/gross cost at 31 March 2017	8,156	122,462	2,150	5,841	45,439	110	12,423	5,828	202,409
Accumulated depreciation at 1 April 2016 - as previously stated	-	8	-	-	36,562	85	11,911	3,396	51,962
Provided during the year	-	2,798	69	-	3,525	5	956	282	7,635
Impairments	-	(416)	-	-	(1,878)	-	-	-	(2,294)
Reversals of impairments	-	(508)	(5)	-	-	-	-	-	(513)
Revaluations	-	(1,903)	(61)	-	(5,776)	-	-	-	(7,740)
Reclassifications	-	45	-	-	(40)	-	-	(5)	-
Transfers to assets held for sale	-	-	(3)	-	-	-	-	-	(3)
Disposals/ derecognition	-	-	-	-	(4,787)	(21)	(3,100)	(372)	(8,280)
Accumulated depreciation at 31 March 2017	-	24	-	-	27,606	69	9,767	3,301	40,767
Net book value at 31 March 2017	8,156	122,438	2,150	5,841	17,833	41	2,656	2,527	161,642
Net book value at 1 April 2016	9,506	118,356	2,224	5,777	20,326	46	2,865	2,771	161,871

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Note 14.2 Property, plant and equipment financing - 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
Net book value at 31 March 2018									
Owned - purchased	8,546	108,541	2,338	5,116	9,678	4	2,715	1,701	**138,639**
Finance leased	-	-	-	-	4,935	-	-	367	**5,302**
On-SoFP PFI contracts and other service concession arrangements	-	20,855	-	-	690	-	10	-	**21,555**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	1,265	-	-	2,900	32	15	259	**4,471**
NBV total at 31 March 2018	**8,546**	**130,661**	**2,338**	**5,116**	**18,203**	**36**	**2,740**	**2,327**	**169,967**

Note 14.3 Property, plant and equipment financing - 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
Net book value at 31 March 2017									
Owned - purchased	8,156	101,621	2,150	5,841	9,384	5	2,602	1,883	**131,642**
Finance leased	-	-	-	-	5,318	-	-	407	**5,725**
On-SoFP PFI contracts and other service concession arrangements	-	19,404	-	-	502	-	47	-	**19,953**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	1,413	-	-	2,629	36	7	237	**4,322**
NBV total at 31 March 2017	**8,156**	**122,438**	**2,150**	**5,841**	**17,833**	**41**	**2,656**	**2,527**	**161,642**

Note 14.4 Revaluations of property, plant and equipment

The Trust's land, buildings and dwellings were revalued by GVA as at 31 March 2018. The Trust's specialised buildings and associated land have been valued using the depreciated replacement cost method, based upon provision of a modern equivalent asset (MEA). A fundamental principle of MEA valuations is that a hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for the existing operations. The valuation of the Trust's specialised land and buildings has therefore been based upon the Trust hypothetically being located on a suitable alternative site away from the town centre, where the cost of the land would be significantly lower, but where the Trust would still be able to re-provide its services. The valuation was carried out in accordance with the terms of the Royal Institute of Chartered Surveyors valuation standard and in accordance with the revaluation model set out in IAS 16.

As shown in note 6, this identified a £7.379m increase in the value of the Trust's land, buildings and dwellings. Of this increase, (£1.981m) has been accounted for as an impairment to the Statement of Comprehensive income and the remaining £9.360m has been recognised as an increase to the revaluation reserve.

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Note 15 Investments in associates and joint ventures

	2017/18	2016/17
	£000	£000
Carrying value at 1 April - brought forward	**117**	**92**
Share of profit	90	31
Reversal of impairment	-	71
Disbursements / dividends received	(103)	(77)
Carrying value at 31 March	**104**	**117**

The Trust holds a 51.4% share of each of Southwest Pathology Services LLP (SPS LLP), Southwest Path Services LLP (services LLP) and SPS Facilities LLP (LLP) .The joint venture, Southwest Pathology Services LLP (SPS LLP), was established to deliver and develop laboratory based pathology services throughout the region. Laboratory processing of tests is carried out by SPS LLP, whilst responsibility for the interpretation of the test results remains with the Trust. The Trust has retained customer contracts for the provision of a complete pathology service with GPs, independent sector providers and other third parties and SPS LLP charges the trust for the cost of processing those tests. During 2013/14 the trust entered into another Joint Venture partnership with Integrated Pathology Partnerships Ltd and Yeovil District Hospital NHS Foundation trust. This 'sister' joint venture, Southwest Path Services LLP, was established to deliver a range of additional testing services to trusts, including point of care testing of patients' glucose levels. These entities are jointly controlled by the Trust, Yeovil District Hospital NHS FT and Integrated Pathology Partnership Ltd. The arrangements are treated as a joint venture and are accounted for using equity accounting, such that 51.4% of the surplus / (deficit) made is included in the trust's SOCI and 51.4% of the net assets of the Joint Venture are included in the SOFP of the trust. In 2014/15 SPS LLP was restructured to form SPS LLP and SPS Facilities LLP.

	SPS LLP		Southwest Path Services LLP		Southwest Facilities LLP		Combined	
	2017/18	2016/17	2017/18	2016/17	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000
Profit and loss account								
Turnover	7,223	7,511	353	298	6,501	6,964	14,077	14,773
Cost of sales	(6,787)	(7,071)	(348)	(291)	(6,142)	(6,574)	(13,277)	(13,936)
Gross Profit	436	440	5	7	359	390	800	837
Operating Expenditure	(326)	(356)	(3)	(6)	(300)	(316)	(629)	(678)
Profit before tax	110	84	2	1	59	74	171	159
Trust's share of profit in Statement of Comprehensive Income	57	43	1	1	30	38	88	82
Statement of Financial Position								
Non current assets								
Current assets	290	232	89	82	233	161	612	475
	290	232	89	82	233	161	612	475
Payables: amounts due within one year	(191)	(119)	(52)	(47)	(167)	(81)	(410)	(247)
Payables: amounts due in greater than one year	0	0	0	0	0	0	0	0
	(191)	(119)	(52)	(47)	(167)	(81)	(410)	(247)
Net Assets	99	113	37	35	66	80	202	228
Share of net assets recognised in the Statement Of Financial Position	51	58	19	18	34	41	104	117

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Note 16 Disclosure of interests in other entities

On 20 January 2015, a company called Openmaxims Community Interest Company was incorporated and registered with Companies House. The Trust owns 1 of 3 £1 shares in this company. The other two shares are owned by Blackpool Teaching Hospitals NHS Trust and St Helens and Knowsley NHS Teaching Hospitals NHS Trust.

The objects of the company are to carry out activities that benefit the community and particularly, but not exclusively, to drive the development of "open source" software in a clinical setting, support research and encourage user participation on a not for profit basis.

The company did not carry out any activities during the financial year. It is planned to wind up the company after preparing the 17/18 financial statements.

Note 17 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	1,300	1,132
Work In progress	-	-
Consumables	23	31
Energy	198	231
Other	2,114	2,375
Total inventories	**3,635**	**3,769**
of which:		

Inventories recognised in expenses for the year were £45,888,000 (2016/17: £37,563,000). Write-down of inventories recognised as expenses for the year were £0 (2016/17: £0).

Note 18 Trade and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	4,095	4,238
Capital receivables (including accrued capital related income)	62	62
Accrued income	6,261	5,061
Provision for impaired receivables	(243)	(240)
Prepayments (non-PFI)	1,421	1,015
PDC dividend receivable	55	59
VAT receivable	785	389
Other receivables	-	701
Total current trade and other receivables	**12,436**	**11,285**
Non-current		
Trade receivables	1,680	1,531
Capital receivables (including accrued capital related income)	5	-
Provision for impaired receivables	(384)	(351)
Total non-current trade and other receivables	**1,301**	**1,180**
Of which receivables from NHS and DHSC group bodies:		
Current	8,546	8,493

Non-current receivables relate to NHS Injury Cost Recovery Scheme. This income is subject to a provision for doubtful debts of 22.84% (22.94% in 2016/17) to reflect expected rates of collection.

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Note 18.1 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**591**	**598**
Increase in provision	46	149
Amounts utilised	(10)	(156)
At 31 March	**627**	**591**

The Trust's policy is to impair specific debts to the extent to which it considers they may not be fully recoverable. Those debts not impaired by the trust are considered to be collectable and of good credit quality.

The value of invoices written off in the year is £9,474 (2016/17: £128,932)

Note 18.2 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	4	-
30-60 Days	2	-	-	-
60-90 days	2	-	-	-
90- 180 days	23	-	-	-
Over 180 days	600	-	587	-
Total	**627**	**-**	**591**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	2,300	-	1,123	-
30-60 Days	730	-	886	-
60-90 days	471	-	166	-
90- 180 days	524	-	195	-
Over 180 days	1,700	-	1,417	-
Total	**5,725**	**-**	**3,787**	**-**

Other Receivables relate to NHS Injury Cost Recovery Scheme income. This income is subject to a provision for doubtful debts of 22.84% (22.94% in 2016/17) to reflect expected rates of collection.

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Note 19 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	£000
groups at 1 April	-	-
Assets classified as available for sale in the year	1,187	217
Assets sold in year	(1,187)	(217)
groups at 31 March	-	-

As at the 31 March 2018, the Trust had no properties (31 March 2017 nil) held for sale.

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	8,027	3,568
Net change in year	(3,122)	4,459
At 31 March	4,905	8,027
Broken down into:		
Cash at commercial banks and in hand	364	139
Cash with the Government Banking Service	4,541	7,888
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	4,905	8,027
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	4,905	8,027

Note 20.1 Third party assets held by the trust

The Trust held cash and cash equivalents which relate to monies held by the the Foundation Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	9	4
Total third party assets	9	4

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Note 21 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	6,897	7,253
Capital payables	4,831	2,815
Accruals	12,823	11,258
Social security costs	3,613	3,444
Accrued interest on loans	70	64
Other payables	-	978
Total current trade and other payables	**28,234**	**25,812**
Non-current		
Capital payables	539	524
Total non-current trade and other payables	**539**	**524**
Of which payables from NHS and DHSC group bodies:		
Current	4,368	1,601

Note 22 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	2,549	2,915
PFI deferred income	259	259
Total other current liabilities	**2,808**	**3,174**
Non-current		
PFI deferred income	3,235	3,494
Total other non-current liabilities	**3,235**	**3,494**

Note 23 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Social Care	648	648
Obligations under finance leases	610	566
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	717	951
Total current borrowings	**1,975**	**2,165**
Non-current		
Loans from the Department of Health and Social Care	12,528	13,176
Obligations under finance leases	3,849	4,461
Obligations under PFI, LIFT or other service concession contracts	10,484	10,802
Total non-current borrowings	**26,861**	**28,439**

The above borrowings relate to finance lease liabilities for items of plant and equipment including those in respect of Energy Infrastructure (see note 24), the Beacon Centre cancer facility and the radiology managed equipment service (see note 29).

Non Current loans from the Department of Health and Social Security are made up of 2 loans: £4,416,000 at an interest rate of 1.5% repayable in full in January 2020 and £8,112,000 at an interest rate of 2.7% repayable in 6 monthly instalments with final payment in June 2031.

Non Current obligations in respect of energy infrastructure amount to £3,849,000 at an interest rate of 7.8% payable in annual installments with final payment in September 2023.

Obligations under PFI, LIFT and other services are made up of 2 balances: Radiology Managed Equipment Service of £285,000 at an interest rate of 3.9% with final payment in June 2027 and The Beacon centre PFI of £10,199,000 at an interest rate of 8.5% with final payment in April 2040.

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Note 24 Finance leases

Note 24.1 Taunton & Somerset NHS Foundation Trust as a lessee

Obligations under finance leases where Taunton & Somerset NHS Foundation Trust is the lessee.

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**5,760**	**6,720**
of which liabilities are due:		
- not later than one year;	960	960
- later than one year and not later than five years;	3,840	3,840
- later than five years.	960	1,920
Finance charges allocated to future periods	(1,301)	(1,693)
Net lease liabilities	**4,459**	**5,027**
of which payable:		
- not later than one year;	610	566
- later than one year and not later than five years;	2,958	2,743
- later than five years.	891	1,718

Leases for energy infrastructure:

During 2011/12, the Trust entered into a contract with a private sector partner, Schneider Electric, for the provision and installation of energy infrastructure assets. The total value of the contract was £7,867,000 and the installation work commenced in June 2011 and was completed during the 2012/13 financial year. The overall leasing commitment for the contract amounts to £7,867,000 and repayments commenced in December 2012 and will be paid annually over the 12 year term of the lease. This is a standard lease paid in periodic fixed annual payments and there are no restrictions or renewable options.

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Note 25.1 Provisions

	Pensions - early departure costs	Legal claims	Total
	£000	£000	£000
At 1 April 2017	**237**	**733**	**970**
Transfers by absorption	-	-	-
Change in the discount rate	2	7	**9**
Arising during the year	-	38	**38**
Utilised during the year	(21)	(80)	**(101)**
Reclassified to liabilities held in disposal groups	-	-	-
Reversed unused	(6)	(3)	**(9)**
Unwinding of discount	1	38	**39**
At 31 March 2018	**213**	**733**	**946**
Expected timing of cash flows:			
- not later than one year;	22	92	**114**
- later than one year and not later than five years;	66	168	**234**
- later than five years.	125	473	**598**
Total	**213**	**733**	**946**

Pensions - early departure costs relate to Pre1995 early retirements. These are calculated on figures supplied by the NHS Pensions Agency and a significant amount of the payments are expected to be greater than one year.

Other legal claims comprises Personal Injury and Injury Benefit claims. Personal Injury provisions are based on the expected values and probabilities quantified by the NHS Resolution. The outcome of these cases are inherently uncertain and the timing of payments is dependent on the progression of each case. The figures included in the summary are based purely on the trust's excess, reflecting the fact that the NHS Resolution make the majority of payments direct. The Injury Benefit provisions are based on figures supplied by the NHS Pensions Agency. A significant amount of the payments are expected to be for a period greater than 1 year.

Note 25.2 Clinical negligence liabilities

At 31 March 2018, £156,564,000 was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Taunton and Somerset NHS Foundation Trust (31 March 2017: £144,762,000).

Note 26 Contingent assets and liabilities

	31 March 2018		31 March 2017
	£000		£000
Net value of contingent liabilities	-	-	-
Net value of contingent assets	-		935

The contingent liabilities at 31 March 2018 were Nil (31 March 2017 Nil).

Note 27 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	759	-
Intangible assets	6,141	-
Total	**6,900**	-

Contractual commitments relate to the Global Digital Exemplar project which was agreed in June 2017 and is funded through external PDC funding from the Department of Health and Social Care.

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Note 28 On-SoFP PFI, LIFT or other service concession arrangements

Note 28.1 The Beacon Centre

The project agreement is with the Taunton Linac Company Limited (the operator) for the provision of an Oncology and Haematology Centre on the Musgrove Park Hospital site (The Beacon Centre) including the supply and maintenance of the building and major medical equipment within the facility. The facility opened in May 2009 and provides state of the art non-surgical cancer services to the residential population of Somerset, in a suitable location and setting at Taunton and Somerset NHS Foundation Trust. The new Oncology and Haematology Centre provides:

- Two Linear Accelerators (a third has been purchased by the Trust)
- One simulation suite with processing and treatment planning facilities
- 18 bed Oncology Ward
- Chemotherapy suite for 22 day patients
- Outpatients suite with 4 consulting and 8 examination rooms

Key Features of the Scheme:

In return for an agreed monthly payment, the following facilities are provided to the Trust by the Operator plus associated hard Facilities Management and asset renewal services:

- Inpatient and Outpatient facilities
- Radiotherapy treatment area
- Administrative offices
- Public spaces

Under the Project Agreement, the above facilities are provided at a pre-determined level of quality for the 30 year term (excluding the construction period).

The operator has also procured, installed, and will maintain and replace major medical equipment for the full 30 years of the operating period. The major equipment requirements include two Linear Accelerators. However, soft Facilities Management services such as portering, catering and cleaning are provided by the Trust and are outside the scope of this PFI project.

Nature of Payment

The Operator provides the services in return for an annual service charge. In covering payment for facilities, other services and financing, the annual service charge is unitary in nature. The Trust has agreed a payment mechanism that incorporates the principles of the NHS Standard Form contract. This relates payment to the successful (or otherwise) achievement of the service and quality standards set out in the output specification. The unitary payment can be abated for instances of non-performance against the standards in the output specification up to a maximum of 100% of the unitary fee, which fall into three areas:

i) Failure events – where there is a failure to meet a specific service standard relating to a particular area of the hospital.

ii) Failure events – relating to the Radiotherapy Equipment.

iii) Quality failures – where there is a failure to supply a service across a wider range of parameters, which cannot be attributed to a specific area of the hospital.

The unitary payment relating to the Beacon Centre is set by the contract between the Trust and the operator and is subject to an inflationary uplift based on the Retail Price Index (RPI). The total unitary payment for 2017/18 amounted to £3,614,000 (2016/17 £3,567,000) and for 2018/19 will be £3,741,000. The value of the liability at 31 March 2018 was £10,802,000 (31 March 2017 £11,753,000) and the net book value of the assets was £13,864,000 (31 March 2017 £13,492,000).

Property ownership

The site on which the new Oncology facilities have been built is in the freehold ownership of the Trust.

Expiry of contract

On expiry of the contract (May 2039), the facility will revert to the ownership of the Trust for no payment.

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Note 28.2 Provision of Multi-Storey Car Park

This is a public private partnership project (PPP). It relates to the building of a car park (completed in October 2006) and the provision of services for 25 years. The ownership of the building will pass to the Trust after the 25 year concession period. The residual value (assessed by professional valuation) is £4,468,000. Throughout this period, the operator pays an agreed proportion of the car parking fees to the Trust; no other financial transactions take place. Since 2009/10, this has been accounted for under International Financial Reporting Standards and the asset together with the outstanding liability is required to be accounted for in the Statement of Financial Position. The asset and liability are summarised below:

	31 March 2018	31 March 2017
	£000	£000
Net Book Value of asset (included in property, plant and equipment, note 14)	6,991	6,467
Liability (see deferred PFI income, note 22)	3,493	3,752

Note 28.3 Managed Equipment Solution for Diagnostic Imaging

On 20 July 2017 the Trust entered into a contract for the provision of a managed service contract within diagnostic imaging. The contract is for the following services:

-A Facilities Infrastructure Replacement Programme (FIRP), which includes the replacement, installation and decommissioning of all assets within the department along with an increase of modalities for ultrasound, MRI and CT scanning;

-The provision of a fully inclusive "Gold Standard" maintenance cover for the department, that includes all parts, durables and labour;

-The provision of a guaranteed uptime availability of the facility to perform diagnostic testing and reporting;

-A consumables management service;

-A full inventory management service;

-Technical training for all modalities;

-Professional training availability for radiographer reporting courses;

-Data collection and analysis to allow for patient level costing within the department;

-Market, professional, technical and analytical intelligence to work in partnership with the Trust, for the purposes of delivering continual improvement in quality and practice across the diagnostic imaging department;

The service provider receives payment in two elements:-

-A managed facility service paid for through a unitary payment fixed for the duration of the contract apart from annual RPI indexation, paid quarterly in advance.

-A consumables management service paid for through a quarterly payment in advance based on an estimate of annual consumption. An assessment of actual Consumables provided is made each quarter and either a balancing invoice or credit note raised as appropriate.

A set of performance parameters has been agreed with the managed service provider. Penalties will apply if performance failures are not corrected within the agreed remedial period.

The accountancy treatment is that ownership of the Trust's existing asset portfolio within the scope of the managed service has been transferred to the managed service provider at fair market value. The assets have been recapitalised to the balance sheet under IFRIC 12. New equipment bought by the service provider has been capitalised under IFRIC 12 where their useful lives are fully utilised during the 10 years of the managed equipment solution agreement. Where new asset lives extend beyond the 10 years of the agreement equipment has been accounted for as operating leases.

The total unitary payment made to the managed equipment solution provider during the 2017/18 financial year for the managed facility service was £1,259,000 (Nil 2016/17) and consumables management service of £435,000 (Nil 2016/17). The values of payments due for 2018/19 for the managed facility service is £2,797,000.

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Note 29 On-SoFP PFI, LIFT or other service concession arrangements

Note 29.1 Imputed finance lease obligations

Taunton & Somerset NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	PFI Schemes	Other Service Concessions	31 March 2018	31 March 2017
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**26,193**	**438**	**26,631**	**28,240**
Of which liabilities are due				
- not later than one year;	1,528	128	1,656	1,956
- later than one year and not later than five years;	4,886	295	5,181	3,250
- later than five years.	19,779	15	19,794	23,034
Finance charges allocated to future periods	(15,389)	(41)	(15,430)	(16,487)
Net PFI, LIFT or other service concession arrangement obligation	**10,804**	**397**	**11,201**	**11,753**
- not later than one year;	605	112	717	951
- later than one year and not later than five years;	809	271	1,080	2,752
- later than five years.	9,390	14	9,404	8,050

The obligations above relates to the Beacon Centre (PFI cancer facility) which opened in May 2009 and the radiology managed facility service (other service consessions) which commenced 1 August 2017.

Note 29.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	PFI Schemes	Other Service Concessions	31 March 2018	31 March 2017
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	78,750	15,891	94,641	77,959
Of which liabilities are due:				
- not later than one year;	3,735	1,718	5,453	3,608
- later than one year and not later than five years;	14,939	6,872	21,811	14,790
- later than five years.	60,076	7,301	67,377	59,561

Note 29.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	PFI Schemes	Other Service Concessions	31 March 2018	31 March 2017
	£000	£000	£000	£000
Unitary payment payable to service concession operator	3,608	1,259	4,867	3,561
Consisting of:				
- Interest charge	1,005	14	1,019	1,071
- Repayment of finance lease liability	951	75	1,026	775
- Service element and other charges to operating expenditure	1,650	1,087	2,737	1,601
- Revenue lifecycle maintenance	2	83	85	114
Total amount paid to service concession operator	**3,608**	**1,259**	**4,867**	**3,561**

Note 30 Off-SoFP PFI, LIFT and other service concession arrangements

Taunton & Somerset NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

Staff Nursery

This is accounted for off the Statement of Financial Position. The operator is required to provide childcare facilities over the concession period, of 30 years from 2003, therefore the arrangement has 15 years to run. The services are provided to trust employees in the first instance and to the public thereafter. The land was provided by the trust on a 99 year lease. Other than this, there is no financial cost to the trust. The land and building will revert to trust ownership at the end of the 99 year lease.

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Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7, dealing with financial instruments, requires disclosure of the role that financial instruments have had during the period 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 listed companies, to which the financial reporting standard mainly applies.
The Trust has the ability to borrow funds and 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 the Foundation Trust regulator, NHS Improvement.

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.
Some of the financial instruments have a fixed interest rate which means the Trust may be 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. Of the financial assets and liabilities set out in notes 31.2 and 31.3, all are denominated in sterling.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. Other credit risk is provided for by the continuous processes of reviewing debt management and ensuring that debts that are unlikely to be collected are appropriately impaired. The Trust reviews all debts over 90 days old to identify specific impaired debts. More recent debt is also provided for where its collection is thought to be doubtful. The total impaired debt (per note 18.2) is £627,000. (2016/17 £591,000)
A significant proportion of the Trust's cash balances are held on deposit with the Government Banking Service, and as such the credit risk on these balances is considered to be negligible.

Liquidity risk
The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and Specialist Commissioners, which are financed from resources voted annually by Parliament. The introduction of Payment by Results has created an inherent risk of performing below the planned activity levels, thereby endangering income. The Trust has mitigated this risk through risk share arrangements within the Somerset Health Community. This arrangement covers the principal commissioner in respect of the majority of its services.
The Trust currently finances its capital expenditure from funds made available from cash surpluses generated by the Trust's activities. The PFI project relating to the Beacon Centre has created liabilities on the Statement of Financial Position that the Trust is committed to meeting for the duration of the service concession. This liability is subject to an annual inflationary uplift. Similarly, the Trust is committed to the Energy Project which added a leasing liability to the Trust's SOFP in 2011/12 and which increased in 2012/13. The Trust is committed to the payment of this leasing obligation for the duration of the 12 year lease term. The Trust has also entered into a radiology managed facility service for a period of 10 years and is committed to meeting the liabilities created on the statement of financial position for the duration of the agreement. In addition, the Trust completed the new surgical ward development (the Jubilee Building) during 2013/14 and supported existing cash reserves to fund this development by drawing against a £12 million loan facility from the Foundation Trust Financing Facility. The approval of major capital projects such as the Jubilee Building are subject to comprehensive project development processes involving the creation of separate project boards, continuous scrutiny by the Trust Board and also through the involvement of NHS partners including the Trust's principal CCG, NHS Improvement and the Area Team of NHS England.
The Trust invests surplus funds in line with its treasury and investment policies. The Trust produces a twelve month rolling cash flow to manage liquidity risk.

The Trust has a planned deficit for the 2018/19 financial year of c£11.2m which the Trust has forecast will require additional cash funding in the form of interim loan support. The Trust made use of an interim revolving working capital support facility agreement with the Department for Health during April 2018 by drawing down £2.82m. The Trust has the ability to apply for further loans as required to support its cash position and expects to do so through the 2018/19 financial year.

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.

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Note 31.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Total book value
	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018				
Trade and other receivables excluding non financial assets	11,476	-	-	**11,476**
Other investments / financial assets	103	-	-	**103**
Cash and cash equivalents at bank and in hand	4,905	-	-	**4,905**
Total at 31 March 2018	**16,484**	**-**	**-**	**16,484**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Total book value
	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017				
Trade and other receivables excluding non financial assets	11,002	-	-	**11,002**
Other investments / financial assets	118	-	-	**118**
Cash and cash equivalents at bank and in hand	8,027	-	-	**8,027**
Total at 31 March 2017	**19,147**	**-**	**-**	**19,147**

Note 31.3 Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	13,176	**13,176**
Obligations under finance leases	4,459	**4,459**
Obligations under PFI, LIFT and other service concession contracts	11,201	**11,201**
Trade and other payables excluding non financial liabilities	25,160	**25,160**
Provisions under contract	946	**946**
Total at 31 March 2018	**54,942**	**54,942**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	13,824	**13,824**
Obligations under finance leases	5,027	**5,027**
Obligations under PFI, LIFT and other service concession contracts	11,753	**11,753**
Trade and other payables excluding non financial liabilities	22,893	**22,893**
Provisions under contract	969	**969**
Total at 31 March 2017	**54,466**	**54,466**

Note 31.4 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	27,199	21,781
In more than one year but not more than two years	5,461	3,456
In more than two years but not more than five years	5,818	4,122
In more than five years	16,464	25,107
Total	**54,942**	**54,466**

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Note 32 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	4	20	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	58	9	50	156
Stores losses and damage to property	-	-	-	-
Total losses	**62**	**29**	**50**	**156**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	28	12	34	9
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**28**	**12**	**34**	**9**
Total losses and special payments	**90**	**41**	**84**	**165**
Compensation payments received		-		-

Losses and Special Payments are reported on an accruals basis, excluding provisions for future losses.

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Note 33 Related Parties

Transactions between the Trust and its related parties are reviewed each year and declared below.

During the year, none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust.

The Department of Health and Social Care 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. A summary of these transactions is listed below.

These transactions represent income and expenditure from a range of services and supplies. Expenditure, for example, includes the purchase of an ambulance service. Income relates to the commissioning of patient care services, the provision of estates services and the sale of drugs.

	Receivables		Payables	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
NHS Somerset CCG	2,255	2	2,523	1,594
Yeovil District Hospital NHS Foundation Trust	392	46	446	171
NHS England	4,144	6,578	496	19
Somerset Partnership NHS Foundation Trust	467	536	485	100
NHS NEW Devon CCG	179	493	15	15
Charitable Funds	140	54	5	5
Other Related Parties (NHS and Government)	2,120	1,347	8,038	7,069
South West Pathology Services LLP	15	62	0	15
SPS Facilities Limited	15	2	0	1
Intergrated Pathology Partnerships Limited	0	0	22	0
Total	**9,727**	**9,120**	**12,030**	**8,989**

	Income		Expenditure	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
NHS Somerset CCG	196,993	182,758	1,032	0
Yeovil District Hospital NHS Foundation Trust	1,502	1,418	1,043	568
NHS England	63,883	73,917	182	22
Somerset Partnership NHS Foundation Trust	4,433	4,208	2,912	2,826
NHS NEW Devon CCG	7,534	6,209	0	0
Charitable Funds	761	639	0	0
Other Related Parties (NHS and Government)	23,340	15,388	47,910	45,789
South West Pathology Services LLP	185	154	6,343	5,401
SPS Facilities Limited	185	154	5,525	5,781
Intergrated Pathology Partnerships Limited	676	471	123	125
Total	**299,492**	**285,316**	**65,070**	**60,512**

The audited accounts of the funds held on Trust have not been consolidated in this annual report and accounts on the grounds of materiality. The aggregate amount of the charity's capital and reserves as at the financial year end is £2,148,000 (31 March 2017: £1,786,000) and the surplus for the year is £362,000 (deficit £20,000 in 2016/17).