NHS

Annual Report, Quality Account and Annual Accounts 2017/18

Yeovil Hospital Healthcare

Yeovil District Hospital NHS Foundation Trust

Annual Report, Quality Account and Annual Accounts 2017/18

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

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1. PERFORMANCE REPORT

History of Yeovil District Hospital and its Statutory Background

The hospital opened in 1973 and was established as an NHS foundation trust on 1 June 2006. It took over the responsibilities, staff and facilities of the previous organisation, East Somerset NHS Trust. As a public benefit corporation, Yeovil District Hospital NHS Foundation Trust ("YDH" or Yeovil District Hospital" or "the Trust") is authorised under the National Health Service Act to provide goods and services for the purposes of the health service in England.

Purpose and Activities of Yeovil District Hospital

Yeovil District Hospital provides outpatient and inpatient consultant services to a catchment population of circa 200,000, primarily from the rural areas of South Somerset, North and West Dorset and parts of Mendip. Services are overseen by the Trust's two strategic business units (urgent and elective care) covering the following areas: A&E, acute and general medical services (including inpatient cardiology, gastroenterology, respiratory medicine, elderly care medicine, diabetes & endocrinology) and a full range of medical outpatient services, critical care, trauma and orthopaedics, emergency and general surgery (including urology, ENT, ophthalmology and oral surgery), oncology, diagnostic services, paediatrics, obstetrics/maternity and gynaecology. The Trust is an accredited Trauma Unit as part of the Severn Trauma Network. It is registered without conditions as a healthcare provider with the Care Quality Commission (CQC). The Trust has no branches outside the United Kingdom.

Statement on the Performance of YDH from the Chief Executive and Key Risks/Issues

Strategic Context

It has been a challenging year for the NHS with continuing unprecedented levels of demand which have been reflected at Yeovil District Hospital. The Trust's catchment population continues to grow and is becoming proportionally older with the district of South Somerset having a much higher proportion of residents aged over 65 (21.6%) than the rest of England (16.3%)[1]. Estimates suggest that by 2030 there will have been a 43% increase in those aged over 55, compared to a static working population. Within this increase, the number of people aged over 85 is forecast to increase by 120%. These challenges are reflected within the wider region including North and West Dorset and parts of Mendip for which Yeovil District Hospital also provides services.

The pressure of this is felt across the local health and social care economy, with ever increasing demand, coupled with difficulties in recruiting sufficient staff to deal with demand and complexity of patient conditions. Despite this pressure, Yeovil District Hospital has, through the introduction of new models of care, stemmed the increase in demand with lower growth rates compared to other NHS organisations, both within the region and nationally. During 2017/18 Yeovil District Hospital was one of a small number of trusts which achieved national performance targets and was routinely within the top five of acute trusts for its accident and emergency waiting times performance throughout the year.

A system wide focus on mitigating future anticipated demand growth has been agreed across Somerset. The aim is to mitigate non-elective growth down to 1.9% with flat elective growth. This will be achieved through a combination of further focus on improving patient

[1] Source: Census 2011

'flow' both within YDH and across the health system and also through targeted investment in community based alternatives to hospital admission. A set of schemes have been worked up across the system and funding identified within the system plan to support them. The key system wide non-elective demand management schemes for 2018/19 are:

- Rolling out of the complex care model across the county, building on the best from the Somerset Vanguard programme;
- Enhancement of 7-day services; for YDH the focus is on developing the Trust's frailty model;
- Development of a community rapid response service with Somerset Partnership NHS Foundation Trust;
- Enhanced programme of working with nursing homes, building on the Trust's AFFECTS programme;
- Implementation of a new psychiatric liaison service and further development of the Somerset 'Home First' service; and
- Focus standardising operational efficiency, including a focus on reducing 'stranded patients'.

The Trust does face significant challenges with regard to finances. A formal investigation into its financial position by NHS Improvement was previously completed. This resulted in no formal enforcement action and there was recognition that Yeovil District Hospital has the right plans and leadership in place to deliver long-term sustainability for the organisation. It concluded that the majority of the underlying deficit and operational challenges are caused by strategic drivers and factors which are to an extent under the control of Yeovil District Hospital but require wholesale restructuring and partnership with other stakeholders to resolve. In addition to this investigation, and in light of the ongoing financial position, the Trust commissioned the support of PricewaterhouseCoopers (PwC) to undertake a review of the Trust's approach to financial improvement and the Trust's 2017/18 cost improvement plans including the identification of further opportunities. The results from this review were considered by the Board of Directors leading to the implementation of additional measures and actions.

Key to sustainably tackling the challenges faced by YDH is the continued expansion and roll out of innovative models of care supported by new partnerships and digital technology. YDH is working with Taunton and Somerset NHS Foundation Trust, Somerset Partnership NHS Foundation, Somerset CCG, Somerset County Council and local GPs as part of the Somerset Sustainability and Transformation Partnership (STP). Trust is on a journey to be part of an integrated care system within Somerset. Key to this development is increasingly close working with local general practice. To support this Yeovil District Hospital has worked with the local GP practices in South Somerset through the Symphony Vanguard programme which ran from March 2015 to March 2018. As part of this the Trust established Symphony Healthcare Services, a primary care wholly owned subsidiary which is now supporting nine practices though a new management model. This work won the British Medical Journal National Primary Care Team of the year award for 2018.

The Trust's wholly owned estates and facilities management company, Simply Serve Limited, commenced operations in February 2018. Simply Serve Limited was created to ensure that the Trust is able to develop cost effective services together with enhancing the ability to recruit and retain key staff groups. This project garnered media attention both on a regional and national basis due to the TUPE of estates and facilities staff to the subsidiary company. The company protects existing jobs, creates new employment opportunities in the local community and ensures the continued quality provision of crucial hospital services. The Trust considers that Simply Serve Limited and all members of staff employed are very much a part of the Yeovil District Hospital group and the values, culture and objectives for the company and the Trust are closely aligned.

During Q4 2018/19 Yeovil District Hospital has further developed the vision and strategy of the organisation in order to better reflect the ambition of the organisation. This new vision and strategy is an evolution of the previous version, and links closely to the Trust's iCARE values with a core focus on patient care and experience. Further information on the updated vision and strategy can be found below.

Our Vision: To care for you as if you are one of our family

Care for our population	Develop our people	Innovate & collaborate	Develop a sustainable system
We will seek and seize opportunities to continually improve the quality, accessibility and safety of our services, and the experience we provide. We will support and encourage our local population to live healthier lives.	We will ensure our teams have the skills, capacity and environment to enable them to provide the care that they aspire to. We will make our hospital an employer of choice.	As part of a sustainable Somerset care system, and working with our partners, we will develop and deliver outstanding services, employing new models of care and innovative technology.	We will manage our resources responsibly to ensure the sustainability of our services and the local care system, without compromising on safety and quality.

The four strategic objectives set out above are supported by a clear set of organisational priorities for the coming year. Progress and the risk to delivering these are overseen via the Trust's Board Assurance Framework.

Our Vision: To care for you as if you are one of our family

Care for our population

Operational priorities

- Improve the care we deliver to patients with mental health conditions, especially dementia.
- Demonstrate outstanding standards of care.
- Deliver RTT, A&E and cancer standards.
- Improve end of life care.
- Develop a new frailty pathway and unit.
- Adopt national best practice in maternity.
- Improve the way we learn from avoidable deaths.
- Encourage people to stay well through self-care.

Develop our people

Operational priorities

- Refresh and embed our iCARE values.
- Develop a clinical workforce strategy taking into account needs of broader system.
- Improve staff retention.
- Listen to, and be informed by our staff.
- Learn and improve through the 'Better place to work' programme
- Improve our GMC survey results and value doctors in training.
- Improve our approach to equality and diversity.
- Implement evolving clinical leaders programme.
- Implement safer staffing guidelines.

Innovate & collaborate

Operational priorities

- Implement systematised surgery including infrastructure.
- Collaborate on roll out of new care models.
- Expand 'Home First' service.
- Implement e-prescribing and STREAMS.
- Data-driven decision making.
- Collaborate on a shared clinical record.
- Move to paper-light systems and virtual appointments.
- Develop innovative career pathways in healthcare.

Develop a sustainable system

Operational priorities

- Meet our control total and CIP target for 2018/19.
- Robust financial grip and support including PLICS.
- Secure sustainability of new care models.
- Transform SHS to be financially self-sufficient.
- Continue progress towards a Somerset Accountable Care System.
- Embed Simply Serve.
- Maximise non-NHS income.

Yeovil Hospital Healthcare

To underpin this strategy, Yeovil District Hospital has a clear set of values that are based on our principles of iCARE. These principles were initially developed eleven years ago by nursing staff and underpin all activities within the hospital; whether it is providing life-saving treatment, how staff relate to one another or our ambition of providing a warm and caring welcome to our hospital.

i Treating our patients and staff as individuals
C Effective communication
A Positive attitude
R Respect for patients, carers and staff
E Environment conducive to care and recovery

2017/18 Performance Summary

Yeovil District Hospital developed a Quality Strategy, approved by the Board in 2015/16 which outlined areas of focus for quality improvement. The strategy incorporates national recommendations, including safe staffing levels, and local priorities that reflect patients' needs. This strategy will be refreshed in 2018/19. Throughout 2017/18, the Trust continued to develop and enhance the seven day services programme. Four core standards under this programme were monitored in the year. The detail of these is outlined within the Quality Account. During 2017/18 the Trust made further progress in increasing the number of services operating across the seven day week, including 24 hour/7 day Critical Care Outreach and weekend pharmacy provision. This expansion of services is a key enabler to prevent unnecessary admissions at weekends, supports discharge processes and ultimately improves the experience and quality of care provided to our patients.

Following the planned CQC inspection of the services in March 2016, the Trust developed a comprehensive action plan and this further informed the Quality Priorities. Progress on this action plan is monitored with improvements identified within the following areas:

- Aspects of infection control across the Trust;
- Improvements in quality assurance for the use of resuscitation equipment in the emergency department, maternity services and children's services;
- Increasing compliance with staff appraisals;
- Strengthening arrangements for End of Life Care in line with National Standards;
- Increased compliance with Level 3 Children's Safeguarding in targeted staff groups and departments.

A further inspection, using the CQC modified inspection process, is anticipated in 2018.

Yeovil District Hospital continues to receive positive feedback through a variety of methods including the iWantGreatCare (iWGC) survey. As of 31 March 2018, the Trust had a star rating of 4.82 (out of a best possible score of 5).

The key performance highlights for 2017/18 are summarised below:

Our year 2017/18

Despite one of the busiest winters on record for the NHS, with exceptionally high demand causing challenges within A&E departments, Yeovil District Hospital achieved the 4-hour A&E waiting times target across the year with 96.9% against the 95% target set by NHS England. National figures illustrate that overall performance for A&E departments in March 2018 was 84.5% and YDH is consistently in the top five hospitals in the country for its performance against this standard. The hospital's A&E department saw a significant increase in the number of people attending compared to previous years, with 50,455 patients

in 2017/18 compared to 46,452 in the previous year. This equates to an increase of 8.6%. The Trust is expected to continue to achieve the target in 2018/19.

Yeovil District Hospital also performed well against the national targets set for Referral to Treatment (RTT) waiting times with 93.3% of patients on ongoing patient pathways waiting less than 18 weeks against the 92% target. No patients are waiting over 52 weeks for treatment and the Trust anticipates that this will be sustained throughout 2018/19. Strong performance was also maintained for diagnostic waiting times and cancer waiting times although there had been some fluctuations during quarter three of 2017/18, in particular against the 62-day standard. This continued good performance bears testament to the commitment and dedication of our staff and volunteers. As a result, Yeovil Hospital is consistently rated as a high performer on both a national and regional basis.

Due to the aforementioned increase in demand, the Trust has continued to experience a significant challenge regarding the financial deficit position of the organisation. The Trust did not achieve its financial control total for the year, a target that is agreed each year with our regulators, NHS Improvement. Initial plans to achieve this control total included the setting of demanding cost improvement plans amounting to a target of £8.7million. Although this target was not met, £7.2million of savings were realised of which 74% were delivered recurrently. This equated to approximately 5% of turnover which benchmarks highly against other NHS organisations.

The Board recognises the significant challenge regarding the deficit position as a percentage of the organisation's turnover. Given the strategic and structural nature of the drivers of the Trust's deficit, Yeovil District Hospital has been a key partner in progressing the vision and objectives of the Somerset Sustainability Transformation Partnership (STP), working collaboratively with local partners to ensure a system response to the countywide deficit position. As such, plans are in development to close the STP system deficit over a three year period together with an in-year focus on cost reduction equating to approximately £7million for YDH, demand moderation and engagement in the Somerset Strategic Health and Care Review which aims to develop new care models across Somerset over the next three years.

Performance Analysis and Assurance

Throughout the organisation structured governance arrangements have been implemented with clear lines of reporting from "Ward to Board" across operational, quality, safety, patient experience and finance, through steering groups and assurance committees, to the Board. The Board monitors and reviews key quality, operational and financial performance metrics on a monthly basis and further scrutiny takes places within the Governance Assurance Committee, the Financial Resilience and Commercial Committee and the Workforce Committee on either a monthly or quarterly basis.

Operational dashboards are monitored and reviewed by individual wards and departments and the urgent and elective care strategic business units. These dashboards include key quality metrics covering infection control, patient safety and falls. The performance metrics for Yeovil District Hospital are set nationally and reported to NHS Improvement who holds the hospital to account along with the Trust's commissioners through contracting arrangements.

Each report or paper received by either the Board or a Board Assurance Committee includes a cover sheet outlining how the relevant information contained within the report links with the strategic priorities of the Trust and the Board Assurance Framework in conjunction with any specific risks which are addressed by the paper. These risks may be relevant and recorded on the corporate risk register and/or departmental risk registers.

The Trust has recently strengthened the remit of the Hospital Management Team meeting for which the executive teams, business managers and clinical directors attend, to include a review of Trustwide performance along with a focus on any specific risks identified through departmental and corporate risk registers. The performance overview includes a review of financial, workforce, quality and operational performance KPIs. Any areas where performance has declined will be reviewed and any risks will be considered.

Group Entities

Yeovil District Hospital has a number of joint ventures and subsidiary companies. Joint ventures are separate entities over which Yeovil District Hospital has joint control with one or more other parties. The meaning of control is where the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. Yeovil District Hospital owns a proportion of the following joint ventures:

- Southwest Pathology Services LLP (15.3%)
- SPS Facilities LLP (15.3%)
- SW Path Services LLP (15.3%)
- Yeovil Estates Partnership LLP (50%)

Yeovil District Hospital owns or has shares in the following subsidiary companies:

- Simply Serve Limited (100%)
- Symphony Healthcare Services Limited (100%)
- Daycase UK LLP (70%)
- Yeovil Property Operating Company (100%)
- Wellchester Innovation Limited (100%)

Simply Serve Limited: Simply Serve Limited commenced operations on 1 February 2018. It provides property and estates management services and other associated services to YDH. It aims to develop more cost effective services, enhance the ability to recruit and retain key staff groups and enhance focus and flexibility on developing additional income generation opportunities.

Symphony Healthcare Services Limited: Yeovil acquired Pathways Ltd on 7 April 2016 from a consortium of GPs. The company was renamed Symphony Healthcare Services Limited, and has been the vehicle through which primary care practices have been integrated. As Symphony Healthcare Services practices, they – and other practices which may choose to integrate in the future – benefit from a larger infrastructure and shared support services such as financial management, IT, HR, and facilities management. So far nine practices have been integrated, and there are plans in place for a further five integrations in 2018 with more expected to follow.

Symphony Healthcare Services was a critical part of the Symphony Vanguard programme designed to stabilise primary care as well as being the vehicle through which new models of care can be delivered. In particular supporting patients to live independently, allowing GPs to focus on those most in need and reducing overnight hospital stays.

Daycase UK LLP: Daycase UK (DCUK) is a subsidiary of Yeovil District Hospital which was formed in June 2016 after an OJEU procurement for a joint venture partner to support efficient day case activity. It is 70% owned by Yeovil District Hospital and 30% owned by Ambulatory Surgery International which is part of AmSurg, a leading US-based daycase facility operator. ASI use their expertise to complement the skills and knowledge of Yeovil District Hospital staff to provide local NHS patients with an efficient day case service.

The longer term plan is to build a new daycase unit on the main hospital site to maximise operational efficiency whilst also freeing up space adjacent to the emergency department to improve non elective services and increase the capacity of the Trust's Emergency Department.

Yeovil Property Operating Company Ltd: Yeovil District Hospital established a subsidiary company, Yeovil Property Operating Company Ltd, to facilitate acquisition of GP practices. It enables former GMS practices to sub contract service delivery to SHS whilst retaining the right to receive notional rent from NHS England. The company was incorporated on 19th January 2016. There are no transactions other than the flow of rent.

Wellchester Innovation Limited: Wellchester Innovation Limited was incorporated on 1 October 2016 to provide consultancy services leveraging YDH's knowledge of innovation in the health sector. The company is dormant.

Yeovil Estates Partnership LLP: Yeovil Estates Partnership LLP (YEP) is a strategic estates partnership with Interserve Prime to provide an estate, infrastructure and service transformation solution to generate value and savings, in line with clinical strategy. The 15-year partnership (established on 29 October 2014) enables the Trust to fully explore all its options and ensures that all options are realistic and fundable, as well as identifying opportunities for the Trust to earn income, which can be reinvested into frontline services.

Further information on all group entities can be found within the Trust's Annual Accounts 2017/18. Yeovil District Hospital has no overseas operations other than recruitment campaigns.

Going Concern

In preparation of the year end accounts the Board is required to undertake an assessment as to whether the Trust will continue as a going concern.

The NHS Improvement Foundation Trust Annual Reporting Manual 2017/18 states that financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative to do so.

There has been no application to the Secretary of State for the dissolution of the Trust and financial plans have been developed and published for future years. As the Trust has operated with a deficit from 2015/16 and plans a further financial deficit in 2018/19 the Board did consider the principle of going concern and ongoing financing of this deficit. The group has now entered a net liabilities position on the balance sheet.

The Trust has received revenue and capital loans from the Department of Health (DoH) enabling the Trust to meet its obligations. The 2018/19 financial plans and cash flow forecasts have been prepared on the assumption that further loan support will be received from DoH, and existing loans will roll over as and when they fall due.

Although these factors represent material uncertainties that cast doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, have concluded that there is a reasonable expectation the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. Therefore, these accounts have been prepared under a going concern basis as set out in IAS 1.

Summary Statement of Comprehensive Income

	Group	Trust
	2017/18	2017/18
	£'000	**£'000**
Operating income from continuing operations	144,892	141,204
Operating expenses of continuing operations	(163,894)	(158,241)
Operating loss	**(19,002)**	**(17,037)**
Finance income	27	200
Finance expense – unwinding of discount on provisions and financial liabilities	(725)	(895)
PDC dividends payable	0	0
Net finance costs	**(698)**	**(695)**
(Losses) on disposal of non-current assets	(68)	306
Share of profit of associate/joint venture	(4)	(4)
Corporation tax Expense	**(46)**	**0**
Deficit for the year	**(19,818)**	**(17,430)**
Revaluation gains and impairment losses – property, plant and equipment	(30)	(37)
Other reserve movements	173	173
Total comprehensive income for the year	**(19,675)**	**(17,294)**

Income

Group		
	2017/18	2016/17
Clinical income	**£'000**	**£'000**
A&E income	6,341	5,331
Community services income	333	0
Elective income	17,072	20,103
High cost drugs Income	10,023	9,968
Non-elective income	35,635	33,761
Other non-protected clinical income	386	382
Other NHS clinical income	31,103	28,319
Outpatient income - Firsts	7,055	5,959
Outpatient income – Follow ups	10,522	9,726
Private patient income	1,935	2,103
Clinical income from activities	**120,405**	**115,652**
Other operating income		
Research and development	682	809
Education and training	4,019	4,177
Receipts of capital grants and donations	1,220	780
Non-patient care services to other bodies	3,241	2,524
Resources from NHS charities excluding investment income	444	4,038
Sustainability and Transformation Fund income	1,834	5,252
Vanguard project income	3,435	3,400
Other income	9,612	8,566
Total other operating income	**24,487**	29,546
Total operational income	**144,892**	**145,198**

Included within ‘other income’ is income relating to car parking, catering, staff recharges, estates recharges and additional other income.

Expenditure

Group		
	2017/18	2016/17
	£’000	**£'000**
Clinical negligence insurance	3,804	2,883
Consultancy costs	923	377
Depreciation and amortisation	4,132	4,044
Drug costs	15,349	14,282
Establishment	4,482	3,021
Fees for Audit:		
- Statutory audit	59	56
- Audit related assurance services	15	11
- Other assurance	7	7
Internal audit fees	54	55
Tax advisory services	26	128
Impairment	221	788
Increase provisions	229	25
Legal fees	410	355
Losses, ex gratia and special payments	43	0
Loss on disposal of property plant and equipment	0	0
NHS charities expenditure	1,529	987
Premises	8,284	9,167
Property, plant & equipment impairments	0	0
Purchase of healthcare from non NHS bodies	3,769	2,180
Rentals under operating leases	582	308
Services from:		
- CCGs and NHS England	575	0
- NHS Foundation Trusts	2,741	3,539
- NHS trusts	453	0
Staff costs:		
- Executive directors'	1,310	1,471
- Other staff costs	100,345	94,509
- Redundancy costs	553	1,054
- Non-executive director costs	117	104
Supplies and services (excluding drug costs)		
- Clinical	8,435	13,368
- General	3,073	2,405
Training	437	590
Transport	921	542
Other	1,016	464
Total Operational Expenditure	**163,894**	**156,720**

Agency Staffing

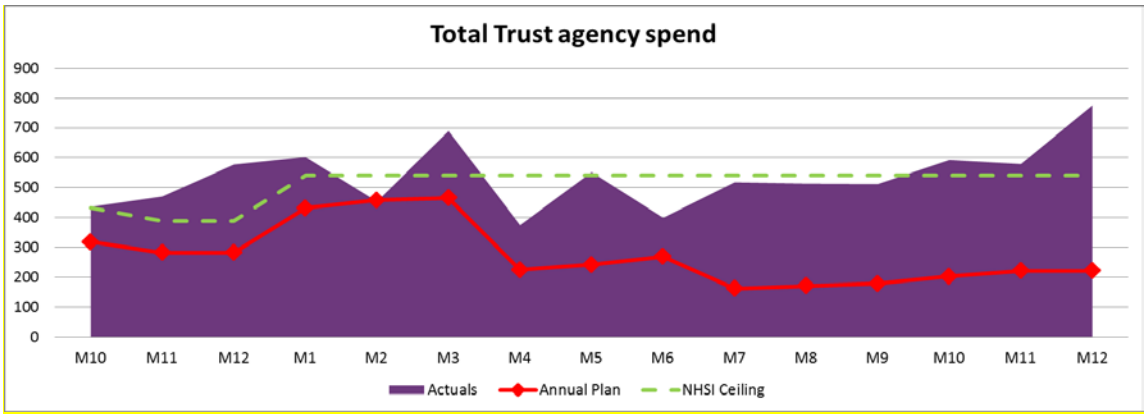
Nursing
During the year the Trust concentrated on nurse recruitment and filling posts substantively, with the aim of reducing our reliance on agency staff. Gradually vacancies have reduced from 80 WTE to 9 WTE. This has led to 17% decrease in agency spend.

Due to the increase of substantive nurses joining the Trust, there has been the introduction of "auto enrolment" to the bank so staff are able to work extra bank shifts easily. This has increased our bank fill rate throughout the year. Trustwide bank fill rates across all staff groups are consistently above 70% with significant successes in nursing and healthcare assistant bank fill rates. However, owing to winter pressures in January, February and March, extra beds were needed which required staffing. This prevented us reducing our nursing agency spend even further.

Going forward, the Trust's nursing recruitment campaign is gathering momentum with an expectation that the Trust will have no nursing vacancies within the coming months. The introduction of the new Nursing Associate role will also support the nursing staff as this role evolves over the next 12 months.

Medical
Due to increases in sickness and issues obtaining VISAs, medical spend has remained high. Medical staffing is the most challenging area of recruitment with locums continuing to demand high pay rates. However, our bank continues to grow and we now have 139 medical staff on the Trust's bank. The Trust is undertaking a workforce review during 2018 to develop a clear strategy to address this clinical workforce challenge in the future. This will include using different clinical staff more effectively in order to bridge medical gaps.

The agency spend through the year is set out below. The Trust was set an agency cap ceiling by NHS Improvement of £6.5million for the year. Spend for the year was £60k (1%) above this ceiling. It was however £3.3million above the more challenging internal plan that the Trust set itself. This is a reflection of the activity and demand challenges outlined earlier within this report.



Capital Investment

£5.3m was invested in capital developments in 2017/18, which included spend on medical equipment, TrakCare (electronic patient record system) development, general site improvements, IT upgrades and construction works including the addition of a new modular admin office, ward refurbishments, Macmillan refurbishment and the reconfiguration of offices on Level 7 to create a Disabled toilet and enhance the lift lobby area.

Cashflow Statement

	Group	
	2017/18	2016/17
	£'000	£'000
Cash flows from operating activities		
Operating deficit	**(19,002)**	(11,522)
Non-cash income and expense:		
Depreciation and amortisation	**4,132**	4,044
Net impairments and reversals of impairments	**221**	788
Income recognised in respect of capital donations	**(1,220)**	(780)
(Increase)/decrease in receivables and other assets	**(4,430)**	(3,685)
(Increase)/decrease in inventories	**(50)**	75
Increase/(decrease) in payables and other liabilities	**8,334**	(1,440)
Increase/(decrease) in provisions	**(315)**	120
Corporation tax (paid)/received	**(47)**	0
Capital, non-cash transactions and non-operating cash flows	**185**	449
Other movements in operating cashflows	**0**	950
Net cash generated from operations	**(12,192)**	(11,001)
Cash flows from investing activities		
Interest received	**16**	19
Payments to acquire intangible assets	**(1,138)**	(1,603)
Payments to acquire tangible fixed assets	**(3,811)**	(6,971)
Sale of property, plant and equipment	**0**	52
Receipt of cash donations to purchase capital assets	**0**	780
Net cash used in investing activities	**(4,933)**	(7,723)
Cash flows from financing activities		
Public Dividend Capital received	**225**	41
Loans received from Department of Health	**17,216**	18,745
Movements on other loans	**(393)**	1,493
Interest paid on loans	**(437)**	(750)
Loans repaid - including finance lease capital	**(143)**	(155)
Interest element of finance lease	**(88)**	(68)
Other capital movements	**(89)**	(64)
PDC dividends paid	**29**	(272)
Charitable fund financing activities	**11**	12
Net cash used in financing activities	**16,331**	18,982
Increase / (decrease) in cash and cash equivalents	**(794)**	258
Cash and cash equivalents at 1 April	**5,426**	5,168
Cash and cash equivalents at 31 March	**4,632**	5,426

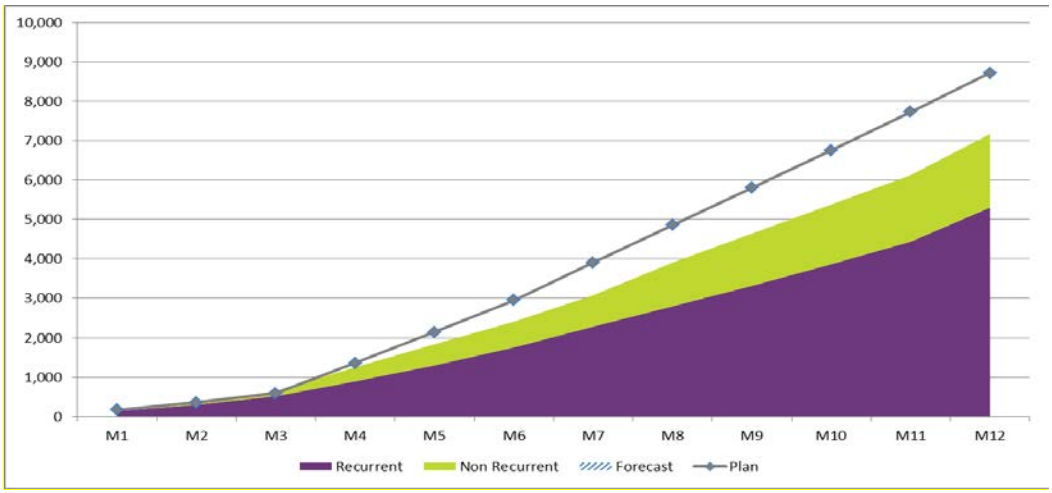
Summary Statement of Financial Position

	Group	Group
	2017/18	2016/17
	£m	**£m**
Non-current assets	63,520	62,064
Current assets	19,728	16,283
Current liabilities	(41,766)	(33,768)
Total assets less current liabilities	**41,482**	**44,579**
Non-current liabilities	(44,087)	(27,735)
Total assets employed	**(2,605)**	**16,844**
Total taxpayers equity	**(2,605)**	**16,844**

Cost Improvement Plans (CIP)

Yeovil District Hospital set a very demanding cost improvement plan target during 2017/18 which was required in order to meet the overall financial control total agreed with NHS Improvement. In year savings of £7,170k were delivered against a target of £8,711k resulting in a shortfall of £1,541k. 74% of cost improvement plans achieved were recurrent. Whilst the target was not achieved, the level of saving continues to be impressive, equating to 5% of turnover.

2017/18 CIP Achieved - Cumulative



Environmental Sustainability

The NHS plays a vital role in the reduction of the UK's carbon dioxide emissions. As such, the operation of Yeovil District Hospital NHS Foundation Trust involves many activities which have an impact on the environment including the use of energy and water, the production and handling of waste and the use of natural resources.

Yeovil District Hospital continues to investigate ways in which its environmental impact can be reduced. A number of key indicators are measured to assist with the monitoring of environmental performance such as utility usage and waste generation. Key indicators are measured and reported within the Trust through regular reports and to the Department of Health through ERIC returns and Model Hospital Dashboard.

The Trust is collaborating with the Estates teams from Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust with regard to sustainability to ensure that Sustainable Development Plans take a consistent approach and to share best practice across the county.

The collaboration group has also engaged with the national lead for sustainability from NHS Improvements Estates team to ensure that the Trust takes advantage of best practice across the entire NHS estate.

The Model Hospital Dashboard data has identified that the Trust's water and sewage costs are higher than the peer group median and to this end the Trust has engaged with the Aquafund National Grant Scheme to provide additional funding and resources to reduce water consumption through investment in metering, infrastructure and training over the next five years.

The Trust continues to meets its obligations under the Building Performance Directive and ensures that Display Energy Certificates (DEC) are in place.

Energy Management

Through the purchase of energy through the Crown Commercial Services Framework, the Trust is able to access energy saving advice and engineering best practice. Yeovil District Hospital compares positively to other organisations using the Model Hospital Dashboard in regard to the rates it achieves for various utilities. The Trust is now in its fourth year of its 15 year energy performance contract with Veolia Ltd (formerly Cynergin Ltd) which continues to deliver the predicted savings to the Trust. Work continues to ensure improvements to reliability and efficiency of the installed equipment such as the investment in the installation of LED light across the estate.

As in previous years, Yeovil District Hospital has engaged in Triad avoidance activities by running the site's stand by generators at times of peak national electrical demand. This has enabled the Trust to make significant savings on its energy costs. The Trust has also invested in its Energy Management software (TEAM Sigma) to provide improved monitoring and targeting information and also to provide a bill checking service.

Waste Management

Yeovil District Hospital ensures that all waste management contracts are aligned with its aim for zero percent of waste to be sent to landfill by 2020. This is being achieved by increasing recycling, and processing of other waste as refuse derived fuel (RDF) which is used to generate electricity.

Yeovil District Hospital continues to actively reduce waste by ensuring:

- All dry mixed recycling products, including paper, hand towels, cardboard, plastic bottles and metal cans is bulk compacted and sorted into its constituent parts for recycling;
- Wood waste has been removed from general waste and is segregated for re-processing and re-use;
- Soft clinical waste is sent for alternative treatment (not incineration) and is then processed as refused derived fuel;
- Reducing packaging used for hard clinical waste, reducing waste sent for incineration;
- Organic waste from our grounds and gardens is either shredded on-site for mulch or sent for composting and re-use; and
- Electronic and electrical equipment waste is sent for recovery and all parts are recycled where possible.

The Trust has been shortlisted for three national awards for its innovative approach to reducing clinical waste by reducing packaging: National Recycling Awards, Edie Sustainable Leaders Awards and NHS Sustainability Awards.

Equality, Diversity and Human Rights

As a public sector organisation, Yeovil District Hospital is statutorily required to ensure that equality, diversity and human rights are embedded into its functions and activities in line with the Equality Act 2010, the Human Rights Act 1998 and the NHS Constitution. In all aspects of business, Yeovil District Hospital will have due regard to achieving the General Duties set out in the Act to:

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Equality Act 2010;
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between people who share protected characteristics and those who do not.

Yeovil District Hospital is working towards removing or minimising disadvantages potentially suffered by people due to their protected characteristics and to take steps to meet the needs of people from protected groups where these are different from the needs of other people. We will encourage people from protected groups to participate in public life or in other activities where their participation is disproportionately low. To achieve the General Duties the following Specific Duties must be achieved:

- Publish information showing that the aims of the General Duty have been considered.
- Publish evidence of equality analysis undertaken.
- Have clear equality objectives.
- Publish details of engagement undertaken.

The Equality Delivery System (EDS2) is a tool that has been developed by the NHS for use by organisations that commission and provide NHS services. The Trust uses the EDS in partnership with patients, the public and staff to review our equality performance and to identify future priorities and actions. As part of its legal obligations and to inform work within the EDS2 Yeovil District Hospital publishes information about our patients and our workforce, examples of which are listed below:

- Workforce Race Equality Standards (WRES): part of the NHS Contract.
- Equality and Diversity Policy (within HR Policy Manual).
- Gender Pay Gap Reporting
- Patient feedback surveys.
- Staff survey.

Internal engagement continues to increase between the equality and diversity team and various hospital departments, as does engagement with members of the local community.

The Trust has contributed to the development of a Workforce Disability Equality Standard (WDES) which will form part of the NHS Contract from April 2018, and will become an annual reporting tool to measure experiences for our disabled members of staff.

Jonathan Higman, Chief Executive, 25 May 2018

2. ACCOUNTABILITY REPORT

NHS Foundation Trust Code of Governance Disclosures

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 Yeovil District Hospital's performance, business model and strategy.

Yeovil District Hospital has applied the principles of the NHS Foundation Trust Code of Governance, most recently revised in July 2014 and based on the principles of the UK Corporate Governance Code issued in 2012.

How the Board of Directors and the Council of Governors Operate (Including the Handling of any Disputes)

The Trust's constitutional documents, relevant legislation and the regulatory framework set out how the Board and the Council of Governors exercise their functions. Yeovil District Hospital retains a register of interest for the Council of Governors and the Board and these are reviewed at least annually. The register for all Board members is presented to the Board of Directors meeting on a monthly basis. The registers are also available, on request, from the Company Secretary and the list of interests of the Board is set out from page 27.

The general duty of the Board and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for its members and for the public. As such, the overall objective of the Board is to secure the long-term success of the organisation. The Board has the same role as that of any other unitary Board – to set strategic direction and to oversee the work of the executive to ensure that corporate objectives and performance targets are achieved. No individual on the Board has unfettered powers of decision. All powers which have not been retained by the Board or delegated to a committee of the Board are exercised on its behalf by the Chief Executive. If the Chief Executive is absent, powers delegated to him may be exercised by a nominated officer after taking appropriate advice from the Chief Financial and Commercial Officer. The Board remains accountable for all of its functions, including those which have been delegated.

The Board may appoint committees consisting wholly or partly of directors, or wholly or partly of persons who are not directors. The committees of the Board are: Audit Committee, Governance and Quality Assurance Committee, Financial Resilience and Commercial Committee, Workforce Committee and a Remuneration Committee (which approves the appointment of executive directors and reviews their performance annually along with their levels of remuneration).

The National Health Service Act 2006 gave the Council of Governors various statutory roles and responsibilities and these were expanded, clarified and added to through the 2012 Act.

The Council of Governors is responsible for appointing and, if appropriate, removing the Chairman and non-executive directors (on the recommendation of the Appointments Committee), for appointing the external auditors and for approving (or not) the appointment of the Chief Executive. It is responsible for deciding the remuneration and other terms and conditions of the Chairman and non-executive directors (on the recommendation of the Appointments Committee), for receiving the annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council of Governors.

The Council of Governors is also responsible for holding the non-executive directors individually and collectively to account for the performance of the Board, representing the interests of members, approving significant transactions and any application by the Trust to enter into a merger, acquisition or dissolution, deciding whether its non-NHS work would significantly interfere with its NHS work and reviewing amendments to the organisation's Constitution.

The Council of Governors comprises elected and appointed governors and is chaired by the Trust Chairman. The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of governors, directors, and other persons to assist it in carrying out its functions. The committees and working groups of the Council of Governors in operation during 2017/18 were: Appointments Committee, Strategy and Performance Working Group and Membership and Communications Working Group. Members of the Board, including the non-executive directors, regularly attend the Council of Governors and their working groups. The Chairman and Chief Executive regularly meet face-to-face with the governors who are also encouraged to attend and observe meetings of the Board and its assurance committees as part of their role. The Governors also partake in Clinical Walkarounds with the Chairman and a member of the Clinical Governance department, attend the various assurance committees and observe the Board of Directors.

During 2017/18, the Council of Governors discharged its statutory duties. The governors contributed to the development of the Trust's forward plans and reviewed key aspects of finance, performance and quality through its various activities. They received the annual accounts and the annual report at the annual general meeting and approved the appointment of two new Non-Executives Directors. To comply with their role to hold the Non-Executive Directors to account, the Council of Governors regularly met with them and requested updates and attended meetings of the Board and its assurance committees.

In the event of dispute between the Council of Governors and the Board, in the first instance the Chairman shall seek to resolve it (on advice from the Company Secretary and/or Senior Independent Director and such other guidance as the Chairman may see fit to obtain). If the Chairman is unable to address 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. If the recommendations (if any) of the special joint committee are unsuccessful, the Chairman may refer the dispute back to an external mediator appointed by an organisation selected by him. There were no disputes between the Council of Governors and the Board during 2017/18.

The Senior Independent Director is available to governors and members should they have concerns which they have not been able to resolve through the normal channels of communication via the Chairman and Chief Executive or for which such contact is inappropriate. To contact the Senior Independent Director, all correspondence, marked private and confidential, should be sent to the Company Secretary at Yeovil District Hospital NHS Foundation Trust, Higher Kingston, Yeovil BA21 4AT.

Audit Function and Audit Committee Role

The Audit Committee has responsibility for providing assurance to the Board concerning the system of internal control, risk management, financial statements and compliance and governance. The Audit Committee oversees the effective operation of the internal and external audit programme and counter fraud activities.

BDO are the Trust's appointed internal auditors and they undertake reviews for the level of assurance on the adequacy of internal control arrangements, including risk management

and governance. The Trust's external auditors are KPMG who provide the Trust's statutory audit services. KPMG also undertake advisory services as and when required. During 2017/18, KPMG reviewed whether their general procedures support their independence and objectivity, including any matters related to the provision of non-audit services, and positive affirmation has been presented to the Audit Committee.

When considering the effectiveness of the external auditors, the Audit Committee:

- Reviews in detail the presentations, reports and communications from KPMG;
- Expects attendance from KPMG at every scheduled Audit Committee; and
- Receives the external audit plan and keeps it under review to ensure the quality of the external audit and to assess any risks of delivery against plan.

In addition, the Non-Executive Director members of the Audit Committee, including the Chair of the Audit Committee, meet separately with KPMG after each meeting and seek views about the executive directors, particularly the Chief Finance and Commercial Officer, as to their effectiveness. KPMG also meet regularly with members of the executive team to broaden their knowledge of Yeovil District Hospital and to provide information on sector developments and examples of best practice. They have built a strong and effective working relationship with the internal auditors to maximise assurance to the Audit Committee, avoid duplication and provide joint value for money. During the year the Audit Committee considered the following significant audit risks identified by external audit:

- Property valuation
- NHS and non-NHS income
- Management override of controls
- Simply Serve Limited transaction (Trust only)

The Audit Committee also considered the value for money risks identified by external audit through risk assessment processes. External audit have provided a qualified opinion this year.

Governors and Membership Information

The Council of Governors meets on a quarterly basis and comprises 13 elected public governors, 5 elected staff governors and 5 appointed governors from other organisations. Members of the public who reside within the Trust's various constituencies elected the 13 public governors. Elected governors (public and staff) are usually appointed for three year terms. There is no time limitation for appointed members. Alison Whitman was lead governor throughout 2017/18 following her appointment from 1 February 2017.

Anyone aged 14 and over that lives in England may become a member of Yeovil District Hospital, subject to a small number of exclusions. The public constituency is divided into six areas, five of which cover core wards and districts served by the hospital across Dorset and Somerset. The sixth constituency (rest of Somerset and England) acknowledges the interest of members from a wider catchment area.

As at 31 March 2018, membership of the public constituency saw a small decrease compared to the previous year at 7,315. Public membership equates to approximately 5% of the Trust's catchment area. As at 31 March 2018, membership of the staff constituency stood at 1,913. The Trust is currently reviewing options to expand the number of partner organisations to cover the subsidiary companies and joint ventures of the Trust.

These partner organisations would then be provided the ability to conduct elections and appoint a partner governor to the Trust's Council of Governors.

Continuous internal quality assurance assessments of membership data are undertaken to promote accuracy, remove duplicate records and resolve any other inconsistencies, which in part accounts for the reduction in public membership compared to the previous year. The membership statistics and details of elected governors across all constituencies are provided as follows:

Public Membership

Constituency	Greater Yeovil	South Somerset (S&W)	South Somerset (N&E)	Dorset	Mendip	Rest of Somerset & England	Total
At 31 March 2018	2,334	1,613	1,760	897	543	168	7,315

Staff Membership

Staff Membership	2017/18
At 31 March 2018	1,913

Elected Governors – Public Constituency

Name	Constituency	Date Elected	Duration of Term of Office (Years)	Attendance at Council of Governor Meetings 17/18
Mary Belcher	Greater Yeovil	01/06/2016	1	3/4
Philip Tyrrell	Greater Yeovil	01/06/2015	3	1/4
John Webster	Greater Yeovil	01/06/2014 01/06/2017	3 1	4/4
Tony Robinson	South Somerset (South and West)	01/06/2016	2	4/4
Sue Bulley	South Somerset (South and West)	01/09/2014 01/06/2017	3 1	4/4
Michael Clark	South Somerset (South and West)	01/06/2017	3	2/4
Sue Brown	South Somerset (North and East)	01/06/2015	3	3/4
Janette Cronie	South Somerset (North and East)	01/06/2017	1	2/4
Nigel Stone	South Somerset (North and East)	01/06/2017	1	4/4
Stephen Hunter*	Dorset	01/06/2017	1	1/1
Jeremy Hughes*	Dorset	01/06/2016	1	0/0
Virginia Membrey	Mendip	01/06/2017	1	4/4
Alison Whitman	Rest of Somerset and England	01/06/2014 01/06/2017	3 1	4/4 4/4

*Stephen Hunter resigned as a public governor in 21 September 2017. Jeremy Hughes resigned as public governor on 5 August 2017. Both vacancies were held until the spring governor elections.

Elected Governors - Staff Constituency

Name	Constituency	Date Elected	Duration of Term of Office (Years)	Attendance at Council of Governor Meetings 17/18
Michael Fernando	Staff	01/06/2012 01/06/2015	3 3	 3/4
Paul Porter	Staff	01/06/2013 01/06/2016	3 2	 4/4
Judith Lindsay-Clark	Staff	01/06/2014 01/06/2017	3 1	4/4 3/4
Fiona Rooke	Staff	01/06/2016	2	3/4
Yvonne Thorne	Staff	01/06/2015	3	3/4

Appointed Governors

Name	Stakeholder Organisation	Attendance at Council of Governor Meetings 17/18
David Recardo	South Somerset District Council	2/4
Rob Childs	Dorset CCG	0/4
Lou Evans	Somerset CCG	1/4
Faye Purbrick	Somerset County Council	2/4
Peter Shorland	Dorset County Council	4/4

Membership Strategy and Representation

YDH recognises the importance of having a strong and representative membership. With approximately 7,300 public members, the Trust has access to an extensive community of users and supporters. The aim during the coming year is to maintain those numbers, to improve the quality of engagement with them and to recruit younger members. YDH has a membership coordinator (Assistant Company Secretary) who works with the communications team and patient experience team to develop and implement the membership strategy. In 2017/18, the governors continued their 'Governor Surgeries' within the outpatient department for direct feedback from members and patients and to assist in the recruitment of Foundation Trust members. These surgeries are planned to be rolled out across the county with proposal for "surgeries" to take in local GP practices. Options are also being explored for evening events for further membership and public engagement.

Public Membership: Gender

	Gender	31/03/2018
Public	Male	2,836 (38.77%)
	Female	4,446 (60.72%)
	Unspecified	26 (0.35%)

Staff Membership: Gender

	Gender	31/03/2018
Staff	Male	355 (19%)
	Female	1,559 (81%)
	Unspecified	0 (0.0%)

Public Membership Representation

	White	Mixed / Multiple Ethnic Groups	Asian/ Asian British	Black / Black British	Other Ethnic Group	Unknown
Public						
31/03/18	6,932 (94.70%)	17 (0.23%)	75 (1.02%)	21 (0.29%)	6 (0.08%)	4 (0.05%)

Staff Membership Representation

	White	Mixed / Multiple Ethnic Groups	Asian/ Asian British	Black / Black British	Other Ethnic Group	Unknown
Staff						
31/03/18	1,541 (80.55%)	15 (0.78%)	166 (8.67%)	24 (1.25%)	49 (2.5%)	123 (6.25%)

White - *British / English / Welsh / Scottish / Northern Irish / Irish / Other White*
Mixed / Multiple Ethnic Groups *- White and Black Caribbean / White and Black African / White and Asian / Mixed Asian and Black African / Mixed Asian and Black Caribbean / Other Mixed*
Asian / Asian British *- Indian / Pakistani / Bangladeshi / Chinese / Other Asian*
Black / Black British *- African / Caribbean / Other Black*

There is a Membership and Communications Working Group of the Council of Governors which was established to set and evaluate strategic priorities in relation to membership and to review recruitment opportunities and activities. The Working Group comprises public and staff governors and reports to the Council of Governors.

Yeovil District Hospital holds events, produces marketing and publicity material and distributes a hospital newsletter to all members. Governors undertake opportunistic recruitment and communication within their communities.

Contact Information for Members

The Assistant Company Secretary acts as the key point of contact for governors. Any member wishing to raise an issue with a director or governor can do so by writing, emailing or telephoning the individual at Yeovil District Hospital, by contacting the Assistant Company Secretary or by speaking to the governor in their constituency. Contact details for directors, governors and the Assistant Company Secretary are available on the YDH website.

Directors Report

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 steps that ought to have been taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

Statement on Compliance with Cost Allocation and Charging Guidance Issued by HM Treasury

Yeovil District Hospital has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

Income Disclosures

The income received from the provision of goods and services for other purposes other than providing healthcare is less than that received for providing healthcare. The other income received enables the Trust to invest in healthcare for the benefit of patients. No political or charitable donations have been made by Yeovil District Hospital.

Better Payment Practice Code

Under the national Better Payment Practice Code, Yeovil District Hospital aims to pay non-NHS invoices within 30 days of receipt.

	2017/18		2016/17	
	Number	£'000	Number	£'000
Total NHS trade invoices paid in year	1,429	6,226	1,926	10,551
Total NHS trade invoices paid within target	667	4,401	1,800	10,076
Percentage of NHS trade invoices paid within target	46.7%	70.7%	93%	96%
Total Non-NHS trade invoices paid in year	51,259	87,699	53,051	77,444
Total Non-NHS trade invoices paid within target	41,075	73,072	49,041	71,582
Percentage of non-NHS trade invoices paid within target	80.1%	83.3%	92%	92%

Quality Governance

The quality report and the annual governance statement provide an overview of the arrangements in place to govern service quality, including descriptions of how the Trust is continuing to improve patient care and enhance the patient experience. Details of Yeovil District Hospital's activities in research and development and information about patient care activities and stakeholder relations are set out in the quality account appended to this annual report.

The Board

The membership, skills and expertise of the Board during 2017/18, together with attendance at meetings, the commitments of the Chair, the length of appointment of the Non-Executive Directors, and any declarations of interests, were as follows:

Paul von der Heyde+* Chairman

Paul von der Heyde joined the Trust Board as a Non-Executive Director in June 2012 and assumed the role of Chair of the Audit Committee from June 2013 – April 2016 and the Board Remuneration Committee from March 2014 – January 2016.

He began his post as Chairman in January 2016. Previous to that he was a Non-Executive Director at the Trust.

Paul was in practice in London for almost 30 years specialising in many clients' business development following which he has led the UK arm of an international group for 11 years.

Paul is also a Fellow of the Institute of Chartered Accountants. He is a Trustee and Advisor of Howlands Furniture Group, Director and Shareholder of Herswell Consulting, Director of Bear Pit Residential Limited and Bear Pit Management Ltd, Chairman of Psoriasis and Psoriatic Arthritis Alliance and PAPAA Enterprises Ltd and Director of Silvatherm Energy Ltd.

Board Attendance: 11/11
Audit Committee Attendance: 5/5
Board Remuneration Committee Attendance: 5/5

Maurice Dunster+ Non-Executive Director

Maurice Dunster joined the Trust Board in June 2012.

After a career as a science teacher Maurice Dunster moved to the John Lewis Partnership. There he held a number of posts including HR Director for the John Lewis Department Store division, and finally Corporate Director of Organisational Development. Maurice is a Director and Trustee of the John Lewis Partnership Pension Fund and a Non-Executive Director of Exeter Primary Care Ltd.

Maurice became Chair of the Workforce Committee in March 18.

Board Attendance: 10/11
Board Remuneration Committee Attendance: 4/5

Julian Grazebrook+* Non-Executive Director

Julian Grazebrook joined the Trust Board in September 2010.

He is a Chartered Accountant. After some years in the City, Julian has spent the last 25 years working with entrepreneurial and owner managed businesses. He has broad commercial and financial experience in a wide variety of industries. Currently he is Director of Eurac Ltd and Chief Financial Officer of MAT Foundry Group Ltd. Julian is Chairman of the Financial Resilience and Commercial Committee and was also the Senior Independent Director.

Julian left the organisation at the end of March 2018.

Board Meeting: 10/11
Audit Committee Attendance: 5/5
Board Remuneration Committee Attendance: 5/5

Jane Henderson+* — Deputy Chairperson / Non-Executive Director

Jane Henderson joined the Trust Board in June 2013.

Jane Henderson has held a number of high-profile regional and national leadership roles, including Chief Executive of the South West Regional Development Agency, Regional Director of the Government Office for the South West and Director of Finance and Funding for the Higher Education Funding Council for England. Previous non-executive board roles include Dementia UK, and Bath Spa University, where Jane was chair of the governing body. Jane is Chair of the Governance and Quality Assurance Committee.

Board Attendance: 11/11
Audit Committee Attendance: 5/5
Board Remuneration Committee Attendance: 4/5

Mark Saxton+ — Non-Executive Director

Mark Saxton joined the Trust Board in June 2012.

Mark Saxton is a UK chartered director and a fellow of the institute of directors. He was appointed having held senior management positions in HR and general management in FTSE and NYSE listed companies, both internationally and in the UK. He runs an executive coaching and outplacement practice and has served on Boards in both charity and commercial enterprises. He was Chair of the Workforce Committee and Chair of the Board Remuneration Committee.

Mark left the organisation at the end of February 2018.

Board Attendance: 10/10
Board Remuneration Committee Attendance: 4/4

Caroline Moore+* — Non-Executive Director

Caroline Moore joined the Trust Board in September 2016.

Caroline Moore is Chair of the Audit Committee. She is a Chartered Accountant and worked for PricewaterhouseCoopers in both London and Bristol until 2002, where she provided audit and consultancy services to a wide range of clients, and had national responsibility for the social housing practice. She joined her current employer, Yarlington Housing Group, in 2002 as Executive Director of Finance and Corporate Services. She has executive responsibility for Finance, HR, IT, Communications, Risk assurance and Governance. She is also a member of the Board of the trading subsidiary Yarlington Homes.

Caroline is the Chair of Simply Serve Limited.

Board Attendance: 11/11
Audit Committee Attendance: 5/5
Board Remuneration Committee: 5/5

Paul Mears	Chief Executive

Paul Mears was Chief Executive from May 2012 – March 2018. Paul left the organisation in March 2018.

Paul Mears joined YDH from his role of Chief Operating Officer at South Devon Healthcare NHS Foundation Trust where he had been since 2009. Previously he was Director of Operations at Torbay Care Trust where he was responsible for integrating community health and social care services in one of the leading examples of integrated care in the UK. Paul joined the NHS through the Gateway Leadership Programme having previously worked in commercial management for British Airways and Eurostar.

Board Attendance: 7/11

Jonathan Higman	Chief Executive

Jonathan Higman joined the Trust Board in January 2009 and became Chief Executive in March 2018. During this time he has held a number of Director level posts, including Director of Strategic Development and Director of Operations at the Trust.

Jonathan graduated from the University of Reading in 1993 and has nearly 20 years' experience working in a variety of roles in both hospitals and commissioning across the NHS in the South West and South East of England.

He is a Director of the Yeovil Strategic Estates Partner Board, which is the partnership between YDH and Interserve Prime, Symphony Healthcare Services Limited, and Wellchester Innovation Limited.

Board Attendance: 10/11

Shelagh Meldrum	Deputy Chief Executive / Director of Nursing & Elective Care

Shelagh Meldrum joined the Trust Board in February 2016.

Shelagh Meldrum joined YDH with a background in nursing and as a clinical services leader in both the NHS and private facilities. Shelagh began her career in the NHS as a senior nurse working in acute medicine, and subsequently as a senior specialist nurse in neurology. She later became a clinical services lead, managing the six departments which formed the directorate of specialist medicine. Following a 14-year career in the NHS Shelagh worked as Head of Clinical Services in various independent healthcare facilities. Shelagh previously worked for Circle Healthcare, opening and holding the position of Registered Manager at CircleBath Hospital for five years and then took up the role of Registered Manager at CircleReading Hospital in 2014.

Board Attendance: 11/11

Timothy Newman — Chief Finance & Commercial Officer

Tim Newman joined the Trust Board in February 2013.

Tim Newman is Chief Finance and Commercial Officer and leads the finance, procurement, estates and hotel services, information technology, human resources, and commercial functions of YDH. Tim joined YDH in February 2013 from Fitness First, a leading operator of health and fitness clubs where he was Finance Director. Prior to Fitness First, Tim held senior roles at United News & Media plc, a global media business, where he was Group Treasurer and then Chief Financial Officer of NOP World, the market research division. Before that he was Group Treasurer at Hammerson plc, a global property investment company. Tim qualified as a Chartered Accountant at PwC after obtaining a law degree at the London School of Economics. He is a director of the Yeovil Strategic Estates Partner Board (which is partnership between YDH and InterservePrime) Symphony Healthcare Services Limited, Yeovil Property Operating Company Limited, Daycase UK and Wellchester Innovation Limited. Tim is also a Governor of the Arts University Bournemouth.

Board Attendance: 11/11

Dr Tim Scull — Medical Director

Tim Scull joined the Trust Board in March 2014.

Tim Scull graduated from Dundee University in 1984. Following training in primary care medicine he joined an anaesthesia programme and was granted Fellowship of the Royal College of Anaesthesia in 1995. In 2000, Tim became a consultant anaesthetist at YDH, his main areas of clinical interest being paediatric and obstetric anaesthesia. Tim has had an interest in medical management for several years, having spent periods as Clinical Director, Divisional Director and Associate Medical Director. In March 2014 he became the Medical Director at YDH. He is also a Director of ATUM Medical Consulting Ltd. His wife is GP Principal in Millbrook Surgery, Castle Cary.

Board Attendance: 10/11

Simon Sethi — Director of Operations and Urgent Care

Simon Sethi joined the Trust Board in June 2015.

Simon leads on operational performance and delivery across YDH with a specific focus on the development and implementation of Urgent Care Strategy. Simon also leads YDH's work with community partners and social care. Simon joined YDH from Gloucestershire CCG where he was Deputy Director of Commissioning responsible for commissioning of ambulance and hospital services worth over £300m. Prior to this he worked in system redesign leading on the creation of the Severn Major Trauma Network and within operational management roles in Surgery and Trauma and Orthopaedics at North Bristol NHS Trust. He is a Graduate of the Management Training Scheme and has an MSc in Healthcare Leadership and Management from Birmingham University and an MBA from Warwick Business School.

Board Attendance: 8/11

Non-voting directors who attended meetings of the Board during the year were:

Mandy Seymour-Hanbury Managing Director of Symphony Healthcare Services

Mandy Seymour-Hanbury joined the Trust Board in November 2015.

As the former Chief Executive of Torbay and Southern Devon Health & Care Trust (previously Torbay Care Trust) and part of the original management team which established this landmark organisation in 2005, Mandy Seymour-Hanbury has almost unparalleled experience of integrated care systems. She joined the YDH Board in November 2015 as Interim Director of Integrated Care. She was appointed as Managing Director of Symphony Healthcare Services in December 2016.

Board Attendance: 9/11

Dr Kathryn Patrick Director of Primary Care

Kathryn Patrick joined the Trust Board in June 2017.

Kathryn graduated from Birmingham University Medical School in 1998 and spent a number of years working in hospitals before qualifying as a GP in July 2004 and gaining her Membership of the Royal College of General Practitioners. Since qualifying, Kathryn has developed specialist skills and knowledge in women's health and contraception services, gaining an additional Diploma from the Faculty of Family Planning.
Over the past three years, as a practicing GP, Kathryn has been instrumental in helping to lead and develop the roll out of new models of care in South Somerset as part of the Symphony Programme Vanguard and is a strong advocate of innovation and change in Primary Care. In addition to her work as a GP within Symphony Healthcare Services, she also supports the hospital in developing Primary Care relationships within the community.

Board Attendance: 4/9

Key
* Indicates member of the Audit Committee
+Indicates member of the Board Remuneration Committee

Further information on all director's declarations of interest are published within the monthly Board of Directors meeting papers which are available on the Trust's website.

Performance Evaluation of the Board/Governance Arrangements (Including Details of External Facilitation)

The Board continuously reviews and considers its expertise and experience and Yeovil District Hospital is confident that it has the necessary skills and capability within the Board and that its balance is complete and appropriate to the requirements of the Trust. The Board is satisfied that Yeovil District Hospital applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS. The Trust has structured governance arrangements in place with clear lines of reporting from "ward to Board" across operational, quality, safety, patient experience and finance, through assurance committees, to the Board.

NHS Foundation Trusts are subject to the recommendations of the *NHS Foundation Trust Code of Governance* (modelled on best practice UK governance principles) and the *Well-Led Framework*, which encourage Boards to conduct a formal evaluation of their own performance and that of its committees and directors.

Accordingly, Yeovil District Hospital took part in a joint Care Quality Commission and NHS Improvement pilot inspection under the new well-led framework in 2017/18 where areas of good practice were identified. A number of recommendations were also identified, such as the suggestion for an enhanced Equality and Diversity Strategy, accompanying action plan and a review of reporting lines and structures. As such, a full action plan was developed together with a Board governance structure review through the various working groups, steering groups, assurance committees and ultimately to the Board of Directors. In addition, the Trust undertook a self-certification well-led survey with support from the Trust's external auditors, KPMG. The results of this survey will form the basis of a report and will instruct the organisation on areas where additional support and improvements may be required. This piece of work will be considered by the Board during quarter one of 2018/19. Further information on internal control, the organisation's performance and future developments of the governance framework is contained within the annual governance statement.

No material inconsistencies between the annual governance statement, corporate governance statement, quality report, annual report and reports from the Care Quality Commission have been identified.

Annual Remuneration Report (Including Senior Managers' Remuneration Policy and Annual Statement on Remuneration)

The Remuneration Committee of the Board is responsible for reviewing and agreeing the salary and allowances payable to and the performance of the Chief Executive and Board level executive directors of Yeovil District Hospital. Details of the membership and the number of meetings held by the Remuneration Committee are contained in the director report from page 27. In 2017/18, the Committee was chaired by Mark Saxton, Non-Executive Director. The Chief Executive and Company Secretary attended the Remuneration Committee during 2017/18 to give advice as required. Graham Hughes attended the committee as an observer in the position of Non-Executive Director Designate. No other person attended the Remuneration Committee to provide advice or services to the committee.

With the exception of the Chief Executive, directors, doctors, and some key functional roles, all staff are remunerated in accordance with the NHS National Pay Structure, Agenda for Change. The Chief Executive and all executive directors are employed on substantive contracts under the very senior managers pay scheme. Between three and six months' notice is required for loss of office as set out in their service contracts. The principles, on which the determination of payments for loss of office will be approached, will be to comply with statutory and contractual obligations and to ensure the continuing effectiveness of the organisation.

When reviewing executive pay, the Remuneration Committee undertakes a competitive benchmarking exercise and considers whether it is set at a sufficient rate to attract, retain and motivate executive directors to successfully lead the organisation and deliver its strategic objectives. While the Trust did not consult with employees on the remuneration policy regarding senior managers, it did take into account the national pay and conditions on NHS employees. The Remuneration Committee adopts the principles of the Agenda for Change framework when considering executive directors' pay. Where an individual Director is paid more than the Prime Minister or is paid more than £142,500, the Trust has taken

steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS Foundation Trusts and that this rate enables the Trust to attract, motivate and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients.

During 2017/18, the Remuneration Committee considered whether the Board had appropriate composition and skill mix to meet the strategic objectives of the organisation and set executive director remuneration to reflect this position. In line with the Trust's strategic priorities, objectives are set for the Chief Executive and executive directors annually and performance is assessed through a formal appraisal process. This is reported annually to the Committee. Pension arrangements for the Chief Executive and executive directors are in accordance with the NHS Pension Scheme. The accounting policies for pensions and other relevant benefits are set out in the accounts.

During 2017/18, following Paul Mears' resignation and subsequent changes with the Chief Executive and Deputy Chief Executive roles together with a reduction in capacity of the Board, the Remuneration Committee reviewed the salaries of Jonathan Higman, Shelagh Meldrum and Simon Sethi.

Fair Pay

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. The banded remuneration of the highest paid director at Yeovil District Hospital in the financial year 2017/18 was £170,000 to £175,000 (2016/17 £185,000 to £190,000). This was 6.12 times (2016/17 - 6.50 times) the median remuneration of the workforce which was £28,074 (2016/17 - £28,479).

In 2017/18, the number of employees receiving remuneration in excess of the highest paid director was five (2016/17 - two). Remuneration ranged from £176,000 to £226,000 in 2017/2018. The employees receiving remuneration in excess of the highest paid director are medical consultants.

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

During 2017/18 there was a public sector inflationary pay award of 1%. Where employees weren't at the top of their pay scale contractual incremental pay increases were applied. There was a slight decrease in median pay between 2017/18 and 2016/17 due to incremental points of leavers and starters.

Expenses of the Governors and Directors

The Trust has policies on the payment of expenses which governs all staff, including directors, governors and volunteers. During 2017/18 the expenses paid to members of the Board and directors attending the Board totalled £13,044. During the same period the expenses paid to the members of the Council of Governors totalled £1,532. The combined sum for expenses was £14,576, which compares to £50,610 for 2016/17.

Salary and Pension Entitlements of Senior Managers 2017/18

Name and Title		2017/18					
		Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(Rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000		£000
P von der Heyde	Chairman	45 - 50	0	0	0	0	45 - 50
J Grazebrook	Non-Executive Director	10 - 15	0	0	0	0	10 -15
M Dunster	Non-Executive Director	10 - 15	0	0	0	0	10 -15
M Saxton	Non-Executive Director	10 - 15	0	0	0	0	10- 15
J Henderson	Non-Executive Director	10 - 15	0	0	0	0	10 -15
C Moore	Non-Executive Director	10 - 15	0	0	0	0	10 -15
P Mears	Chief Executive	260 - 265	0	0	0	77.5 - 80	340 - 345
J Higman	Director of Strategic Development/ Deputy Chief Executive Chief Executive	120 - 125	100	0	0	227.5 - 230	235 - 240
T Newman	Chief Finance and Commercial Officer	170 - 175	1,500	0	0	62.5 - 65	235 - 240
S Sethi	Director of Urgent Care and Long Term Conditions	100 - 105	0	0	0	52.5 - 55	150 - 155
Dr T Scull	Medical Director	155 - 160	0	0	0	0	155 - 160
M Seymour-Hanbury	Managing Director of SHS	135 -140	0	0	0	0	135 - 140
S Meldrum	Deputy Chief Executive / Director of Nursing and Elective Care Acting Deputy Chief Executive	125 - 130	0	5-10	0	0	135 - 140

Notes
M Saxton left the Trust in February 2018.
P Mears left the Trust in March 2018. The data above includes a loss of office payment.
J Higman's role changed during the year.
S Meldrum's role changed during the year.
T Scull's salary includes pay for his clinical and non-clinical responsibilities.

Salary and Pension Entitlements of Senior Managers 2016/17

Name and Title		2016/17					
		Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(Rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£	£000	£000		£000
P von der Heyde	Chairman	40 - 45	0	0	0		40 - 45
J Grazebrook	Non-Executive Director	10 - 15	0	0	0		10 - 15
M Dunster	Non-Executive Director	10 - 15	0	0	0		10 - 15
M Saxton	Non-Executive Director	10 - 15	0	0	0		10 - 15
J Henderson	Non-Executive Director	10 - 15	0	0	0		10 - 15
C Moore	Non-Executive Director	5 - 10	0	0	0		5 - 10
P Mears	Chief Executive	185 - 190	400	0	0	137.5 - 140	320 - 325
Dr L J Howes	Deputy Chief Executive	175 - 180	0	0	0	175 - 177.5	350 - 355
T Newman	Chief Finance and Commercial Officer	170 - 175	1,700	0	0	127.5 - 130	300 - 305
H Ryan	Director of Nursing and Clinical Governance	90 - 95	0	0	0	25 - 27.5	115 - 120
J Higman	Director of Strategic Development	90 - 95	400	0	0	35 - 37.5	125 - 130
S Sethi	Director of Urgent Care and Long Term Conditions	90 - 95	0	0		82.5 - 85	175 - 180
Dr T Scull	Medical Director	155 - 160	400	0	0	60 - 62.5	215 - 200
M Seymour-Hanbury	Chief Officer for Integrated Care	135 - 140	0	0	0	0	135 - 140
S Meldrum	Director of Elective Care	95 - 100	400	0	0	0	100 - 105

Notes
The salaries of J Howes and T Scull include pay for their clinical and non-clinical responsibilities.
J Howes stepped down from the Board on 1 December 2016

Pension Benefits of Senior Managers 2017/18

Name and Title		Real increase in pension at pension age (bands £2,500)	Real increase in pension lump sum at pension age (bands £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
P Mears	Chief Executive	2.5 - 5	0 - 2.5	35 - 40	75 - 80	484	51	540	0
T Newman	Chief Finance and Commercial Officer	2.5 - 5	0 - 2.5	20 - 25	0 -5	230	55	287	0
J Higman	Director of Strategic Development/Deputy Chief Executive Acting Chief Executive	10 - 12.5	22.5 - 25	35 - 40	90 - 95	392	197	592	0
S Sethi	Director of Urgent Care and Long Term Conditions	2.5 - 5	0 - 2.5	15 - 20	30 - 35	142	31	177	0
Dr T Scull	Medical Director	0	0	0	0	0	0	0	0

Notes: As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members. The remaining benefits in kind relates to the additional mileage allowance paid over and above the Inland Revenue allowance. A Cash Equivalent Transfer Value (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. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accumulated in their former scheme. The pension figures shown relate to the benefits that the individual has accumulated 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 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 accumulated to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. Real increase / (decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accumulated pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

T Scull opted out of the pension scheme for 2017/18
T Newman opted out of the pension scheme part way through 2017/18

Pension Benefits of Senior Managers 2016/17

Name and Title		Real increase in pension at pension age (bands £2,500)	Real increase in pension lump sum at pension age (bands £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
P Mears	Chief Executive	5 - 7.5	0 - 2.5	30 - 35	75 - 80	386	98	484	0
Dr L J Howes	Medical Director	7.5 - 10	5 - 7.5	60 - 65	165 - 170	944	172	1,116	0
T Newman	Chief Finance and Commercial Officer	5 - 7.5	0 - 2.5	15 - 20	0 - 5	142	88	230	0
H Ryan	Director of Nursing and Clinical Governance	0 - 2.5	2.5 - 5	35 - 40	105 - 110	735	46	781	0
J Higman	Director of Strategic Development	0 - 2.5	0 - 2.5	25 - 30	65 - 70	357	35	392	0
S Sethi	Director of Urgent Care and Long Term Conditions	2.5 - 5	0 - 2.5	10 - 15	30 - 35	111	31	142	0
Dr T Scull	Medical Director	2.5 - 5	7.5 - 10	60 - 65	185 - 190	1,193	88	1,282	0

Notes: As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members. The remaining benefits in kind relates to the additional mileage allowance paid over and above the Inland Revenue allowance. A Cash Equivalent Transfer Value (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. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accumulated in their former scheme. The pension figures shown relate to the benefits that the individual has accumulated 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 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 accumulated to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. Real increase / (decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accumulated pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Jonathan Higman, Chief Executive, 25 May 2018

Staff Report

Yeovil District Hospital is immensely proud of its dedicated staff who provide the best possible care they can for patients whilst continually looking for new and innovative improvements. The Trust continues to work hard to engage with staff and has developed a nurse retention strategy together with initiatives to improvement staff health and wellbeing, and the introduction of a number of career development opportunities and leadership programmes. The Trust has the ambition to be the best NHS Trust to work for.

The Trust employs the following people (as at 31 March 2018):

Headcount (Excluding Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	3	6	9
Non Executives & Chairman	2	3	5
Other Senior Managers	39	21	60
All other employees	1909	531	2473
Grand Total	**1953**	**561**	**2547**

Headcount (Including Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	3	6	9
Non Executives & Chairman	2	3	5
Other Senior Managers	39	21	60
All other employees	2453	693	3146
Grand Total	**2497**	**723**	**3220**

Full-Time Equivalent (Excluding Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	3.0	6.0	9.0
Non Executives & Chairman	2.0	3.0	5.0
Other Senior Managers	37.2	21.0	58.2
All other employees	1557.9	486.6	2044.5
Grand Total	**1600.0**	**516.6**	**2116.6**

Full-Time Equivalent (Including Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	3.0	6.0	9.0
Non Executives & Chairman	2.0	3.0	5.0
Other Senior Managers	37.2	21.0	58.2
All other employees	1559.8	487.6	2047.4
Grand Total	**1601.9**	**517.6**	**2119.5**

The average number of employees employed by Yeovil District Hospital:

Average Number of Employees (Full-Time Equivalent)	2017/18			2016/17
	Permanent	Other	Total	Total
Medical and dental	143.8	111.7	255.4	247.9
Administration and estates	484.6	40.4	525.0	578.9
Healthcare assistants and other support staff	428.1	41.7	469.8	426.8
Nursing, midwifery and health visiting staff	518.3	54.1	572.4	566.6
Scientific, therapeutic and technical staff	241.6	37.3	278.9	266.9
Total Average Numbers	**1816.36**	**285.1**	**2101.46**	**2087.1**

Staff Costs

Group	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	78,522	73,394
Social security costs	7,517	6,618
Employer's contributions to NHS pensions	8,707	8,411
Agency/contract staff	6,561	7,517
NHS charitable funds staff	0	40
Apprenticeship levy	348	0
Termination benefits	553	1,054
Total staff costs	102,208	97,034

Absence Data

Our absence rate was 3.71% (as at 28 February 2018). The Trust aims to maintain a low absence rate and our score compares favourably with national average absence rates for acute trusts of 4.36%. The Trust is also focused on keeping our people well and has developed a number of programmes to assist in this including health and wellbeing initiatives. Monthly absence reports are available to managers to help them manage absence with support from their Human Resources Business Partner.

Equality, Diversity and Human Rights (Including Policies Relating to Disabled Persons)

As a public sector organisation, The Trust is statutorily required to ensure that equality, diversity and human rights are embedded into its functions and activities as per the Equality Act 2010, the Human Rights Act 1998 and the NHS Constitution. Anyone who is an employee of Yeovil District Hospital, or who uses NHS services as a patient, has a right to be protected from discrimination and be treated fairly. To this end, and in common with other NHS trusts across the country, Yeovil District Hospital has taken part in numerous initiatives and embedded good practice within the organisation. We are also a disability symbol user.

To ensure equality of opportunity, the Trust supports disabled persons working at the hospital to access learning and development opportunities. This includes meeting with them individually and putting in place a tailored support plan. From this, additional requirements to support their learning may be identified such as additional time and/or access to resources. For medical and nursing students, any support needs are aligned with those of the university to which they are affiliated. However, we want to go above and beyond what is statutorily required. We want to be an organisation that not only embraces equality and diversity, but embeds fairness and inclusion into everything that we do.

Staff Policies and Actions applied during the Financial Year

Yeovil District Hospital complies with the Equalities Act and the 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. Such policies apply to those who become disabled persons during the year requiring the provision of tailored measures to ensure that the needs of disabled employees are met. All employees are treated equally, and provisions are made for reasonable adjustments where required. The Trust also actively encourages people with disabilities to apply for roles within the Trust, and each year we provide opportunities for young people to gain work experience working within different areas of the hospital.

Actions on Areas of Concern and Involvement of Staff in the Improvement of Performance

Involving our people in addressing areas of concern is essential, and the Trust is keen to develop a culture of openness where our people can freely express their concerns without fear of reprisal. Raising a concern early can prevent minor issues becoming more serious and thus avoid an adverse incident. The focus of this approach is to protect the public from harm and improve standards of care.

Senior manager presence on wards is really important and executive and non-executive directors regularly visit wards and departments to find out more about the work people do and discuss any concerns they may have relating to the service delivered to patients, enabling our people to discuss day-to-day operational issues.

Yeovil District Hospital has two ‘Freedom to Speak up Guardians’ together with a ‘Freedom to Speak up Guardian for Daycase UK. This is combined with a simple accessible process for raising concerns. We have also increased use of social media such as blogs and Twitter as a mechanism of interaction, in addition to regular team meetings, and monthly meetings for all staff and managers. Weekly newsletters are also produced which include details of key quality improvement information.

Our people are also encouraged to stand in staff governor elections and become directly involved through the Trust’s governance structure. The five staff governors come from a variety of posts within the Trust, both clinical and non-clinical. The role of staff governor allows employees to strengthen the link between their workplace communities and the broader decision-making process.

Health and Safety

Throughout 2017/18 fire, health and safety arrangements and procedures have been strengthened. A fire door replacement and upgrade programme has taken place with the focus on maintaining safe evacuation routes and improving the fire alarm system in higher risk building areas. With the focus on building cladding materials and fire safety standards a review took place on the type and location of materials used. Reassurance was provided

that the cladding type fitted to limited areas of the building does not pose a fire risk. In addition, a programme of replacing fire damper actuator systems has taken place whilst maintaining cleaning with kitchen extract systems. Fire safety liaison visits with the Fire & Rescue Services have taken place with fire evacuation practices supporting and testing emergency arrangements.

Security procedures have been thoroughly revised with lockdown arrangements practices and plans revised for dealing with suspicious packages and arrangements for responding to telephone call threats. The missing patient's procedures have been revised with staff training focussed at safeguarding higher risk patients. Assessments of the clinical environments for reducing ligature risks and placement of higher risk patients have taken place with safety improvements identified and actioned.

Both conflict resolution training for higher risk staff groups and physical intervention training have been carried out with security staff. With the introduction of innovative patient handling equipment aids, such as slide sheets, a programme of training has been focussed specifically to improve patient handling and staff safety through 'snack box' training.

Lighting in public corridors and in offices has been improved through a programme of lighting reviews, helping to prevent slips and trips. During 2017/18 a specific focus has taken place with reviewing safe storage and handling of hazardous substances to reduce the likelihood of harm and spillages occurring. A review of all medical gas cylinder storage points has taken place with improvements in the storage, signage and availability of cylinders across the Trust.

Occupational Health

The Trust has a nurse-led Occupational Health service with physician input as required. Managers can refer members of staff for support through an online portal, or by telephone, and receive a dashboard which provides regular updates on the progress of the referral.

A range of management information is provided which enables us to identify key areas in which work is needed. We are focussing our attention on the top three reasons for sickness absence, namely musculoskeletal, stress and mental health and we are working with key stakeholders to support the health of our people.

Yeovil District Hospital also has an 'Employee Assistance Programme' in place to support our people by offering specialist information on a range of topics such as counselling, debt management support, stress intervention support, and career guidance. All our people are able to access the service via a freephone hotline, which is available 24 hours a day 365 days a year, or by using a website with comprehensive information and guidance.

Counter Fraud and Corruption

We comply with the Secretary of State's directions on countering fraud. All anti-fraud and corruption work is overseen by the Chief Finance and Commercial Officer who is regularly updated on the progress of anti-fraud work within Yeovil District Hospital through liaison with, and reports produced by, the Trust's local counter fraud specialist (LCFS) who is employed through TIAA. The LCFS provides regular progress reports and concluding investigation reports to the Audit Committee. The Trust's counter fraud arrangements and procedures are set out in the Anti-Fraud, Bribery and Corruption Policy.

Engaging our People

Trusts that engage with their people have a better chance of success and are more likely to deliver safe and effective care. Therefore, Yeovil District Hospital identifies the engagement and involvement of its people as a key priority. A new 'staff engagement steering group' has been recently set up to development this area.

To ensure staff remain informed and can feedback their successes and concerns, we use a range of corporate communication channels, known as CONECT, in conjunction with multiple two-way staff meetings and briefings and our intranet, YCloud.

Our suite of CONECT communications includes a weekly newsletter, all staff emails for operational and internal initiatives and monthly staff meetings featuring the iCARE Champion award along with questions submitted by staff. Trust wide meetings such as Big Gov and Schwartz rounds enable staff to come together to learn and discuss how they can provide the best patient care possible. For staff unable to attend meetings in person we use recordings to make them as accessible as possible. This includes our Chief Executive, Jonathan Higman recording a summary of our board meetings which is shared on YCloud. Our YCloud-based incident reporting system gives staff an effective way of highlighting where we can improve. Other methods include the 'An Even Better Place to Work' digital engagement tool and the piloting of a new engagement app.

Our approach to staff engagement is one of celebrating the excellent work of our staff, the pinnacle of which is our annual iCARE awards. The awards recognise and celebrate the exceptional performance of our staff and volunteers across nine categories such as the Lifetime Achievement Award and the Rising Star Award.

Staff Networks for BAME, Carers, Bereavement, Disability/Impairment/Illness and LGBTQ are under development to provide 'safe spaces' for staff with shared interests and characteristics. These networks will be run by the members and will provide opportunity to discuss experiences, share ideas and contribute their collective voices to the organisation's strategic goals and visions through links with the Equality and Diversity Forum, whilst providing peer support and guidance.

Towards the end of 2017/18, the Trust developed an Evolving Clinical Leaders programme with the aim to change the perception of clinical leadership, identify and develop talent, and create a programme of meaningful, evidence-based training which will improve the professional skills-set of members of staff. This programme is intended to be implemented during the first quarter of 2018/19.

Staff Survey

The 2017 Staff Survey has shown improvements in many areas and whilst there is a lot more to do, we are moving in the right direction and the results are encouraging. Our response rate was 58% which compares favourably with the national average of 44%. The results are good in many areas, with year-on-year increases in rates of positive responses against the majority of questions. Similarly, we have recorded higher rates of positive responses than national comparators.

This is particularly notable given the financial challenge which the whole Trust has been addressing, and the changes underway amongst a number of services, and is due in no small part to the quality and effectiveness of leaders and the positive 'team spirit' which continues to thrive here at the Trust.

Some of the headlines for this year were:

- 78% of staff feel their manager is supportive;
- 3.83 out of 5 staff are positive about team working;
- 57% of staff reported that managers ask staff for their opinion;
- 71% of staff felt we take a positive interest in their health and wellbeing;
- 86% report that training has helped staff do their job effectively; and
- 86% of staff are encouraged to report errors or near misses, and are treated fairly.

However, there are some things we still need to improve on, such as:

- 27% of staff reported that Trust values are not discussed at appraisal;
- 57% of staff would recommend YDH as a place to work; and
- 53% of staff receive feedback on incidents reported.

In response to our survey results we have developed an action plan, which includes:

- Continue with our Leadership Development Programme;
- Continue on our H&WB journey but go even faster;
- Roll-out 'An Even Better Place to Work' more widely;
- Improve quality of appraisal process; and
- Improve incident reporting processes.

The survey results have been shared with staff, and we are involving them in developing improvement plans in their own area of work to make the Trust a fantastic place to work and receive care.

Our top five ranking scores with comparison to the national average for all acute foundation trusts, were as follows:

Top 5 Ranking Scores	2017/18	
	Trust	National Average
Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	45%	52%
Support from immediate manager*	3.87	3.74
Percentage of staff experiencing harassment, bullying or abuse from staff in the past 12 months	20%	25%
Percentage of staff / colleagues reporting most recent experience of harassment, bulling or abuse	51%	45%
Effective team working*	3.83	3.72

** The minimum score is 1 and the maximum score is 5.*

Our lowest 5 ranking scores, again with comparison to the national average for acute foundation trusts, were as follows:

Lowest 5 Ranking Scores	2017/18	
	Trust	National Average
Percentage of staff agreeing that their role makes a difference to patient / service users	88%	90%
Percentage of staff appraised in last 12 months	80%	86%
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	16%	15%
Fairness and effectiveness of procedures for reporting errors, near misses and incidents*	3.70	3.73
Staff recommendation of the organisation as a place to work or receive treatment*	3.72	3.75

** The minimum score is 1 and the maximum score is 5.*

Our top five ranking scores with comparison to the national average for all acute foundation trusts in 2016/17, were as follows:

Top 5 Ranking Scores	2016/17	
	Trust	National Average
Percentage of staff experiencing physical violence from staff in last 12 months	1%	2%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	20%	25%
Support from immediate managers	3.85*	3.73*
Percentage of staff feeling unwell due to work related stress in the last 12 months	31%	35%
Percentage of staff satisfied with the opportunities for flexible working patterns	55%	51%

** The minimum score is 1 and the maximum score is 5.*

Our lowest 5 ranking scores, again with comparison to the national average for acute foundation trusts in 2016/17, were as follows:

Lowest 5 Ranking Scores	2016/17	
	Trust	National Average
Percentage of staff appraised in last 12 months	80%	87%
Staff satisfaction with the quality of work and care they are able to deliver	3.83*	3.96*
Effective use of patient/service user feedback	3.66*	3.72*
Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	59%	56%
Percentage of staff agreeing that their role makes a difference to patients/service users	89%	90%

** The minimum score is 1 and the maximum score is 5.*

Future Priorities and Targets

Yeovil District Hospital is only as good as its people so there is a focus on making Yeovil Hospital the best place to work of any NHS Trust. The Trust is driven by its core values and we want to empower our people to do their very best, every day.

The Trust has just come to the end of its three year Organisation Development Plan, which focussed on maximising the potential of everyone. We are now working in partnership with other trusts in Somerset to develop a new system-wide Organisational Development Plan.

Yeovil District Hospital will continue to invest in its people and develop its managers. There is recognition that managers shape the way by providing a positive atmosphere for our people to be creative. We therefore strongly believe that as an organisation we need to nurture and develop our talent to be successful in the future.

Expenditure on Consultancy

£923k – includes work undertaken to support key strategic projects throughout the organisation, within HR supporting our workforce, finance and procurement and other corporate advice including STP and cost improvement plans.

Off-payroll Arrangements

Nothing to declare.

Exit Packages

	2017/18	2017/18	2017/18	2016/17
	Compulsory redundancies	Other departures	Total Number	Total number
< £10,000	2	3	5	16
£10,001 - £25,000	1	3	4	12
£25,001 - £50,000	1	2	3	9
£50,001 - £100,000	0	1	1	3
£100,001 - £150,000	1	0	1	2
£150,001 - £200,000	1	0	1	0
Total Number	**6**	**9**	**15**	42
Total resource cost	**£327,000**	**£226,000**	**£553,000**	**£1,055,000**

Other (non-compulsory) departure payments

	2017/18	2017/18	2016/17	2016/17
	Number of Agreements	Value of Agreements	Number of Agreements	Value of Agreements
Mutually agreed resignations (MARS) contractual costs	8	132	34	£725,000
Contractual payments in lieu of notice	1	94	3	£26,000
Total	**9**	**£226,000**	**37**	**£751,000**

Non-Contractual Departure Payments

There were no non-contractual departure payments made.

Board Members and/or senior officials with significant financial responsibility

	2017/18
	Number of Engagements
Number of off-payroll engagement 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".	14

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 Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence. Yeovil District Hospital did not receive any notices from NHS Improvement stating that the Trust was in breach of 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 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.

Yeovil District Hospital NHS Foundation Trust has been placed in segment 2. This segmentation information is the Trust's position as at April 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement 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	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4
Financial efficiency	I&E margin	4	4	4	4	4	4
Financial controls	Distance from financial plan	4	4	4	2	2	1
	Agency spend	2	1	1	1	1	2
Overall scoring		**4**	**3**	**3**	**3**	**3**	**3**

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Yeovil District Hospital NHS Foundation 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 Yeovil District Hospital 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 Yeovil District Hospital 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 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 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*.

Jonathan Higman, Chief Executive, 25 May 2018

Annual Governance Statement

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Yeovil District Hospital 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 Yeovil District Hospital for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As Accounting Officer, the Chief Executive is ultimately responsible for the leadership of risk management and for ensuring the organisation has adequate capacity in place to handle risk. The Board oversees that appropriate structures and robust systems of internal control are in place, supported by the Audit Committee and Risk Assurance Committee.

The Director of Nursing and Elective Care is the designated executive director with Board level accountability for clinical quality, safety and risk management. The Medical Director and Chief Executive support this role. Yeovil District Hospital has a designated Risk Manager within the clinical governance department together with a Maternity Risk Manager.

The Non-Executive Director who chairs the Audit Committee, supported by the Governance and Quality Assurance Committee, independently reports to the Board with assurance on the appropriateness and effectiveness of risk management and internal control processes. A Risk Assurance Committee, chaired by the Medical Director, reviews compliance against the Care Quality Commission standards across the Trust's regulated activities. This process allows for a systematic review of compliance, providing assurance and highlighting areas of risk and focus for improvement.

To ensure that a risk management culture is embedded across the Trust, there are actions in place to guarantee that staff are clear as to their responsibilities with regard to risk management with communication of the risk management strategy amongst staff. Guidance and training is provided by the Risk Manager to all new senior members of staff on the risk management process at Yeovil District Hospital. Additional on-going training is also provided through the management development programmes, principles of leadership training and nursing band 6 leadership programmes. The Risk Manager meets regularly with risk owners and service leads to ensure all risks on the risk register, and identified risks managed locally within departments, are scored, actioned and reviewed appropriately.

Following a piece of advisory work by the internal auditors (BDO) and external reviews on maternity risk maturity the Trust undertook a focus on strengthening the governance and risk arrangements within maternity services. A number of recommendations were implemented in 2017/18 including the development of a more proactive approach to identifying risks. This approach requires the alignment of services risks against departmental objectives, alongside any actions required for mitigation. A review of the Maternity Risk Management Strategy was completed during 2017/18 and was incorporated into the Trust's Risk Management Strategy. This allows for consistency across services and the alignment of processes. A full review of the Maternity Risk Register was completed following a period of stagnation with a number of entries where progress had not been recorded. As such, more in-depth reviews of the register are completed on a regular basis by the Maternity Risk Management Committee which complements the high level review undertaken at the Maternity Risk Management Committee meetings. These processes ensure that the register is maintained at a standard which facilitates effective risk management within the department.

Training

Risk management training is completed through various in-house channels at Yeovil District Hospital; this training is designed to equip staff with the necessary skills to enable them to manage risk effectively. The Trust's induction programme ensures that both clinical and non-clinical staff are provided with details of internal risk management systems and processes. This trust-wide induction is augmented by local orientation within each department or specialty. For members of staff who are likely to be risk owners or services lead, additional training and induction is provided by the Risk Manager. In addition, and to act as a reminder, all members of staff are required to complete mandatory training. This training reflects the essential training needs and includes risk management processes such as fire, health and safety, manual handling, resuscitation, infection control, safeguarding and information governance. Skills and competencies are also assessed for medical device equipment and for blood transfusion to ensure safety in care. E-learning and workbooks support this programme and are provided as the preferred model of training.

Root cause analysis training is provided to staff members who are required to complete investigations. Additional training for managing safety alerts is provided on a needs basis. Learning from national and internal reports and from external and internal investigations is presented at the Board, the assurance committees and/or their sub-groups.

The remit of the Patient Experience Team and the management of complaints and PALs process were integrated into the Clinical Governance Department in 2017. Learning from incidents and claims is presented through the Patient Safety Steering Group and Integrated Learning Forum whilst complaints are reviewed through the Patient Experience Committee and Integrated Learning Forum. These committees and/or forums continually identify opportunities for improvement with the learning cascaded via monthly peer review and governance meetings.

The Trust continues to exhibit areas of good practice with regard to integrated learning and the embedding of a learning culture throughout the Trust. This includes ensuring all responses from investigation managers are SMART actions, with allocated responsible officers and clear implementation dates. To aid this, all managers have been reminded of their responsibilities and been provided with guidance on developing SMART actions accompanied by a template action plan for completion. A review of responses is regularly undertaken by the Patient Experience Team with spot checks on department led investigations to ensure that actions have been identified. Other areas of good practice include the use of the Safeguard complaints and incident management system with in-built stages to assist departments in completing their investigations and recording required outcomes. Monitoring reports for complaints and incidents are produced and monitored by

management and the Board of Directors. The Governance and Quality Assurance Committee receive an in-depth review of the Patient Experience Department on a quarterly basis with the Board receiving a high level update on the learning from complaints and incidents on a monthly basis as part of the Trust's Operational and Financial Reports.

Yeovil District Hospital also understands the importance of audits and uses these to ensure that processes in place throughout the Trust are robust and of required standards. Where recommendations have been presented, the Trust reviews these through the relevant department and Board assurance committees to make further improvements in methods of working.

The Risk and Control Framework

Risk management processes are set out in the Trust Risk Management Strategy, which was reviewed and updated in 2017/18 and approved by the Audit Committee. This strategy demonstrates the organisational risk management structure which details that all committees have a shared responsibility for managing risk across the organisation. The Trust recognises that there is an acceptable level of risk within the Trust; this may be defined as potential hazards that are either small enough to have an immaterial effect on the achievement of organisational objectives, or are significant risks that have been mitigated by the establishment of effective controls. A Trust risk appetite statement has been agreed by the Board and is clearly communicated within the Risk Management Strategy. This statement identifies what level of risk is acceptable at departmental level and at which point this risk is required to be escalated. Systematic identification of risks starts with a structured risk assessment with identified risks documented on departmental risk registers. These risks are analysed in order to determine their relative likelihood and consequence using risk matrix scoring.

- Risks scoring 6 and under are managed by the area in which they are identified.
- The strategic business units review and assess risks rated 8 and above.
- Risks scored at 12 and above are captured within a corporate risk register which is reviewed by the Hospital Management Team (which oversees the Strategic Business Units) and is monitored by the Assurance Committees and the Board on a quarterly basis.

The Trust's Risk Management Strategy outlines who has overall responsibility for managing risk in their areas. Risk registers are held for each of the Strategic Business Units and include all operational risks. Managers implement action plans and review the risks in line with the review dates set.

The Trust's Quality Improvement Strategy 2015-2018, which is due for planned review in 2018/19, is aimed at achieving excellence in clinical care. The Quality Report for 2017/18 outlines the progress made in areas of patient safety, clinical outcomes and patient experience. The Patient Safety Steering Group monitors all patient safety improvement, with information on quality and patient safety is received monthly by the Board and scrutinised in depth on a quarterly basis by the Governance and Quality Assurance Committee. The Data Quality Steering Group, Information Governance Steering Group and BDO as internal auditors review data quality elements.

The Trust aims to promote a high level reporting, low level harm culture with regard to incident reporting with monitoring processes in place to identify errors and risks. These are analysed for trends to prevent reoccurrence. Should an investigation be triggered, this is

reviewed by the Clinical Governance team and any identified learning is reported back through clinical teams. At all times, members of staff are encouraged to report incidents with support provided by managers and through training. One example is junior doctors meeting on a monthly basis to share their learning and experiences within a “no-blame” environment and undertaking quality improvement projects which are presented to the Board at a seminar session.

Yeovil District Hospital utilises the national reporting and learning system (NRLS) for the reporting of serious incidents together with mechanism to ensure action on safety alerts, recommendations and guidelines made by all relevant central bodes such as NHS England, the Medical Healthcare Regulatory Authority (MHRA) and the National Institute for Health and Care Excellence (NICE).

The Risk Assurance Committee has an annual work plan for the assessment of key areas in line with national standards. This approach provides the ability to identify area of compliance risk and co-ordinates action plans for mitigation. The Governance and Quality Assurance Committee receives exception reports from the Risk Assurance Committee on a quarterly basis. The impact and requirements of Care Quality Commission regulation are reflected within internal procedural documents. The quality, operational, financial and workforce performance report presented each month to the Board is categorised under the Care Quality Commission standards. Regular monthly teleconferences with quarterly face-to-face meetings take place between the Trust and the regional Care Quality Commission to review any recent complaints, incidents, risks and learning etc. The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

A comprehensive CQC inspection took place in March 2016 with the final report published in July 2016. The Trust was given an overview rating of Requires Improvement and a summary of the findings and actions taken were outlined in the Annual Quality Account 2016/17. A comprehensive action plan was developed as a result of the inspection and informed the Trust’s Quality Priorities. Progress against this action plan was reviewed and monitored via the Governance and Quality Assurance Committee.

Yeovil District Hospital took part in a joint Care Quality Commission and NHS Improvement pilot inspection under the new well-led framework in 2017/18 where areas of good practice were identified together with recommendations for improvement such as the implementation of an enhanced Equality and Diversity Strategy and accompanying action plan and a review of reporting lines and structures. In addition to this, the Trust undertook a self-certification well-led survey with support from the Trust’s external auditors, KPMG. The results of this survey will form the basis of a report and will instruct the organisation on areas where additional support and improvements may be required. This piece of work will be considered by the Board during quarter one of 2018/19. A further inspection, using the CQC modified inspection process, is anticipated in 2018/19. The Care Quality Commission did not take enforcement action against YDH during 2017/18.

It has been a challenging year for the NHS with continuing unprecedented levels of demand which have been reflected at Yeovil District Hospital. These challenges are reflected within the wider region including North and West Dorset and parts of Mendip for which Yeovil District Hospital also provides services.

The pressure of this is felt across the local health and social care economy, with ever increasing demand, coupled with difficulties in recruiting sufficient staff to deal with demand and complexity of patient conditions. Despite this pressure, Yeovil District Hospital has, through the introduction of new models of care, stemmed the increase in demand with lower growth rates compared to other NHS organisations, both within the region and nationally. Yeovil District Hospital was one of a small number of trusts which continuously achieved

national performance targets and was in the top five acute trusts for its accident and emergency waiting times performance. However, the Trust continues to face significant challenges with regard to finances.

The Trust still faces a number of risks continuing into 2018/19, including:

- Increased demand, emergency admissions, acuity of patients and closure of community beds resulting in the opening of escalation areas, cancellation of elective activity and risks to quality of care;

- Extended use of escalation areas due to high levels of non-elective admissions and acuity of patients. Financial risks in relation to safe staffing, mixed sex accommodation, non-urgent elective activity, NHS Improvement agency cap and Trust's financial position. The risks are further increased due to loss of income as a result of cancellations of elective activity;

- Insufficient inpatient capacity and Child and Adolescent Mental Health Service support for children requiring acute admission to paediatrics;

- Scale of current financial deficit as a proportion of turnover which could result in increased regulatory oversight by NHS Improvement;

- Risk to financial sustainability as a result of continuing deficits.

In order to maintain the hospital's position and the level of patient safety and care, the Trust has been required to open a number of escalation areas leading to an increase in agency usage. This in turn has a financial implication and affects the Trust's financial position. In order to mitigate this, communication has taken place with external providers including Clinical Commissioning Groups and community hospital providers to ensure full utilisation of patient pathways and community beds and to raise public awareness regarding other NHS services such as NHS 111 and out of hours services.

A Symphony Complex Care Team continues to provide a better way of supporting people living with three or more specific long-term conditions alongside the addition of a Home First service with the aim of getting patients home. The creation of new models of care and services such as the Trust's Frail Older Persons Assessment Unit (FOPAS) and the Ambulatory Emergency Care department have also played vital roles in reducing the number of emergency admissions through the assessment and review of patients within outpatient style settings.

To mitigate the financial risks, YDH commissioned the support of PricewaterhouseCoopers (PwC) to undertake a review of the Trust's approach to financial improvement and the Trust's 2017/18 cost improvement plans including the identification of further opportunities. During 2017/18, the Trust continued to invest in a number of schemes that the Board considered vital in ensuring it maintained the quality of care provided to its patients. These included:

- Meeting safer staffing levels;

- Tag Care, a system of mitigating the risk of falls in a defined cohort of patients;

- Increasing junior medical cover and out of hours support services;

- Increasing midwifery staffing levels;

- Focusing on infection prevention and control; and

- Appointment of the Freedom to Speak Up Guardian and Guardian of Safe Working.

The Board has reviewed the areas of focus for quality improvement and developed a Quality Strategy that incorporates national recommendations, including safe staffing levels, and local priorities that reflect patients' needs. In addition, plans to develop and implement models to provide enhanced seven day services, which will be a key enabler to preventing admissions at weekends and facilitating discharge, will improve the experience for patients.

Given the strategic and structural nature of the drivers of the Trust's deficit, Yeovil District Hospital has been a key partner in progressing the vision and objectives of the Somerset Sustainability Transformation Partnership, working collaboratively with local partners and primary care, including radical new models of integrated care with the aim to ensure a sustainable, high quality health and social care system. Significant progress has been made; key highlights of which include:

- The growth of Symphony Healthcare Services, the Trust's wholly owned Primary Care subsidiary, which has seen the integration of nine GP practices to date, with another five undergoing the due diligence process, all of whom are anticipated to be integrate within the coming months.

- Roll out of the new complex care and enhanced primary care models with over 15,000 patients having been touched by one of these models. Evidence suggests that this is starting to have a tangible impact on acute demand as evidenced by Symphony operational dashboards and there are plans to roll these new models of care out across the wider region.

- The continual development of new patient pathways through Daycase UK, a joint venture between YDH and Ambulatory Surgery International (a major international provider of daycase surgery). Daycase UK has delivered a number of efficiencies within the existing day surgery footprint and there is the long term aim for the development of a stand-alone day surgery unit to provide further efficiencies and improve patient care and experience.

- Key enhancements to the Trust's physical infrastructure, including the expansion of the outpatient department.

The Board is satisfied that YDH applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS. The Trust has structured governance arrangements in place with clear lines of reporting from "ward to Board" across operational, quality, safety, patient experience and finance, through assurance committees, to the Board.

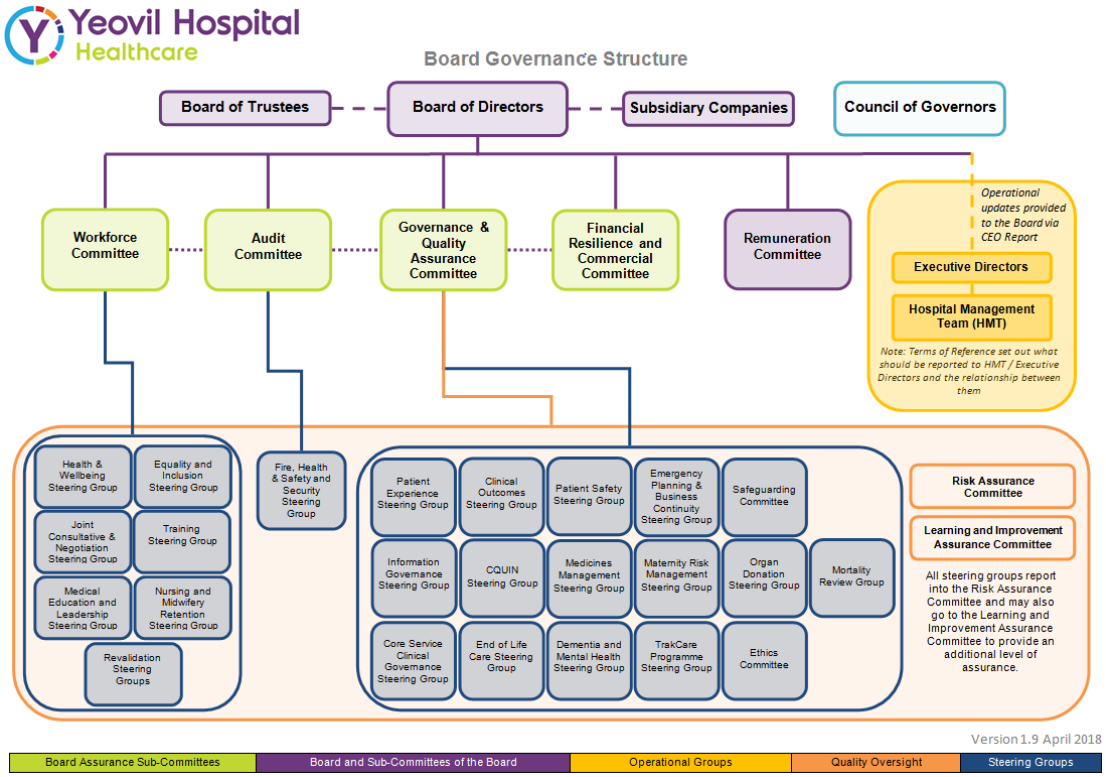
To ensure compliance with Condition 4 (Condition FT4) of the Trust's license with NHS Improvement, which relates to governance, NHS foundation trusts are subject to the recommendations of the NHS Foundation Trust Code of Governance (modelled on best practice UK governance principles) and the Well-Led and Use of Resources Frameworks, which encourage Boards to conduct a formal evaluation of their own performance and that of its committees and directors. Accordingly Yeovil District Hospital took part in a joint Care Quality Commission and NHS Improvement pilot inspection under the new well-led framework in 2017/18. The Trust also commenced a well-led survey in conjunction with KPMG to review the Board's self-awareness, to consider its performance and for the

development of plans to address any key findings. The results of this exercise are due to be presented to the Board in quarter one of 2018/19 whereby an action plan containing the key recommendations will be drafted and implemented.

The Trust has a standardised rolling agenda programme for the Board and its assurance committees, accompanied by a development programme for the Board shaped through Board seminar sessions and Board monthly developmental away days. Following the joint Care Quality Commission and NHS Improvement well-led pilot inspection, a review of the governance structure and assurance committees was undertaken where clarity was sought regarding the quality reporting aspects. This resulted in the review of the remit for the Governance Assurance Committee to become the Governance and Quality Assurance Committee and the previous Quality Committee was renamed to become the Trust's Risk Assurance Committee.

The Workforce Committee advises the Board on the strategic, transformational workforce agenda and reviews the monthly HR data sent to the Board. In addition, it focuses on agency staffing rates and the expenditure, mandatory training, appraisal, occupational health, sickness management and ESR data quality. The Governance and Quality Assurance Committee, together with the Audit Committee, meets on a quarterly basis. A further clarification of the roles, responsibilities and reporting structures was commenced in quarter four of 2017/18 in addition to previous developments outlined and it is intended that these will be introduced during the first quarter of 2018/19.

During 2017/18, the Board received a revised governance structure in January 2018 following a review of the corporate governance structure, through the various working groups, steering groups, assurance committees and ultimately to the Board of Directors. It is intended that this structure would be rolled out across the Trust in the first quarter of 2018/19 and is shown below:



There are constructive working relationships in place with key public stakeholders, including governors, NHS Improvement, NHS England, and the Somerset and Dorset Clinical Commissioning Groups. Where specific issues arise, these are addressed through proactive and candid dialogue or via scheduled monitoring meetings.

Governors are invited to observe each meeting of the Board and regularly participate in the functioning of the Board assurance committees alongside the Financial Resilience and Commercial Committee, Workforce Committee, Risk Assurance Committee, Audit Committee and Governance and Quality Assurance Committee.

During 2017/18, Yeovil District Hospital held its annual general meeting along with the opportunity for members of the public to interact with staff from various departments and to provide feedback.

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.

Emergency Preparedness, Resilience and Response

Yeovil District Hospital completes annual assurance to ensure it is compliant with the statutory requirements placed upon it under the Civil Contingency Act (2004), the terms and conditions of the NHS Standard Contract for Emergency Planning and the NHS Commissioning Board Standards for Emergency Preparedness, Resilience and Response (EPRR).

In the year September 2016 to September 2017 it was recognised internally and through external assurance that YDH had improved assurance against the core standards and October 2016 assurance registered as Green across the 1-37 core standards for EPRR. The assurance process for CBRN undertaken by SWAST on behalf of NHS England also confirmed that YDH were meeting Standard 38-51 CBRN (and separate CBRN equipment list) and were passed as Green.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

As outlined earlier in the annual governance statement, the NHS has experienced a difficult year resulting in a challenged economic environment. This is as a direct result of the continuing unprecedented levels of demand on health and social care, coupled with a static working age population, difficulties faced in the recruitment of substantive staff alongside the increasing complexity of patient conditions. While the Trust has a history of excellent performance and sound financial management, due to the strategic nature of the Trust's deficit position a system wide response is required. The Trust implemented a number of cost control measures. To aid this piece of work, YDH commissioned the support of PricewaterhouseCoopers (PwC) to undertake a review of the Trust's approach to financial improvement and the Trust's 2017/18 cost improvement plans including the identification of

further opportunities. The results from this review were considered by the Board of Directors leading to the implementation of additional measures and actions. In the short-term, and as a consequence of the planned deficit budget in 2018/19, the Trust requires short term financial support in the way of loans from the Department of Health. As a result of the financial position, the external auditors provided a qualified opinion for 2017/18.

A previous investigation completed by NHS Improvement into the Trust's financial position resulted in no formal enforcement action and recognised that Yeovil District Hospital has the right plans and leadership in place to delivery long-term sustainability for the organisation through the creation of new models of integrated care and national recognition with the award of Vanguard status. To ensure ongoing monitoring and scrutiny, operational and strategic plans are reviewed by the Board and by the governor Strategy and Performance Working Group.

Each year, budget setting is completed through detailed analysis by qualified accountants within the finance team using current year actuals as a baseline. The team in turn liaises with various departments and managers on the proposed budgets which are amended, if required, following this input. The executive directors then consider the draft budget prior to full consideration by the Financial Resilience and Commercial Committee and ultimately by the Board of Directors. This robust process ensures that resources are planned on an economic, efficient and effective basis.

The Trust's performance is monitored via the quality, operational and financial performance quadrant at monthly meetings of the Board in addition to the full operational and financial reports. Operational management and the co-ordination of services are delivered by the strategic business units. Performance is reviewed bi-weekly by the Hospital Management Team. During the year, project management leads worked with the Strategic Business Units to achieve improvements in quality, productivity and economic efficiency.

The Trust's internal audit operational plan includes sections on financial assurance and managing resources effectively; the findings of any audits are reported to the Audit Committee. There is also scrutiny as to the economy, efficiency and effectiveness of the use of resources as part of the external audit plan.

The first phase of implementation of the Trust's electronic patient record system, TrakCare, was implemented in 2016/17 as part of the SmartCare project with continued developments and improvements to the TrakCare system took place in 2017/18. The second phase is planned for 2018/19 and will allow the hospital to realise the real benefits of becoming a paperless hospital, with enhanced clinical functionality, electronic notes and electronic prescribing.

Information Governance

Version 14.1 (2017/18) of the Information Governance Toolkit was submitted at the end of March 2018 with a score of 77% and meeting a Level 2 compliance across all 45 criteria of information governance management, confidentiality, data protection, information security, secondary use, clinical information and corporate information assurance. The Information Governance Toolkit remains an essential tool in monitoring progress against national standards and assessment of information security is undertaken annually as part of this process.

An active working group has been created to ensure the Trust is working towards compliance under the new General Data Protection Regulations (GDPR) which will come into force 25 May 2018. An action plan is in place and is being implemented to ensure the Trust continues to process information fairly and lawfully, only retains information for as long

as needed, stores information securely, records who has access to it, gives patients their information when they ask for it and reports any data breaches. More information about GDPR can be found on the Information Commissioner's Office (ICO) website www.ico.org.uk.

In line with the IG reporting tool, four Level 2 incidents relating to information being disclosed in error have been reported to the ICO in 2017/18. Each incident has been fully investigated; improvement plans created and additional targeted IG training sessions made available. The ICO were notified of all four incidents and have investigated the incidents. The ICO decided in three of the incidents that no further action by the ICO was necessary but recommendations were made for the Trust to take forward. The Trust awaits a final decision from the ICO for the remaining Level 2 incident. Data security and information governance breaches are reported and monitored through the Information Governance Steering Group, which reports to the Governance and Quality Assurance Committee.

The Senior Information Risk Owner is the Chief Financial and Commercial Officer.

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 Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*. To provide assurance that the quality report presents a balanced view, the following arrangements are in place:

- Information in relation to quality, safety and patient experience is considered by the relevant sub-groups and the strategic business units. Data is presented to the Board on a monthly basis and scrutinised by the Governance and Quality Assurance Committee (which is chaired by a non-executive director) on a quarterly basis.

- Operational and executive leads present to the Governance and Quality Assurance Committee to enable the opportunity for debate about quality measures and any key risks.

- Data quality is analysed monthly by the information team.

- The Patient Safety, Patient Experience and Clinical Outcomes Committees monitor safety incidents, complaints, mortality and clinical audit reports and the data presented to review progress against the quality strategy and to produce the Quality Report.

- The Deputy Director of Nursing leads quality improvement work jointly with the Clinical Director for Patient Safety and members of the Patient Safety and Quality Team.

- Compliance with NICE guidance is measured and monitored through the Clinical Business Units and the Clinical Outcomes Committee. A high level oversight is provided quarterly to the Governance and Quality Assurance Committee.

- External sources of information are used to inform the Quality Report, including outcomes of inspections and peer reviews and monitoring of mortality rates provided by CRAB Clinical Informatics.

- Quality measures and CQUINs (Commissioning for Quality and Innovation) are agreed with the Somerset Clinical Commissioning Group and these are monitored in-year through the CQUIN Steering Group.

- The Quality Report in draft form is externally reviewed by the Somerset Clinical Commissioning Group, HealthWatch and the Somerset Overview and Scrutiny Committee.

- The local indicator for the Quality Accounts is selected by the Council of Governors and monitored by them on a quarterly basis alongside quality and patient safety updates from the Director of Nursing.

- Assurance is gained through the annual internal audit programme and by the work of the external auditors in reviewing the quality report indicators.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within Yeovil District Hospital who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Governance and Quality Assurance Committee and Risk Assurance Committee; a plan to address weaknesses and ensure continuous improvement of the system is in place. The terms of reference for the committees are reviewed on an annual basis to ensure adequate oversight of all aspects of the Trust together with ensuring an effective system is in place. A full work schedule for each committee is drafted and considered by the committee for the year ahead.

The Trust's risk management strategy outlines the process for maintaining the effectiveness of the system of internal control. Assurance as to the effectiveness of the system of internal control is primary overseen by the Audit Committee, which reports to the Board, supported by the Governance and Quality Assurance Committee. Where weaknesses are identified, recommendations are made and action plans for improvement monitored through this assurance process to ensure continuous improvement of the system in place.
The assurance committees also review the Risk Assurance Committee work plan and governance framework in respect of their assigned risk review areas, reporting directly to the Board.

The 2017/18 internal audit programme was implemented which was adapted in-year to adjust for the risk profile. The recommendations have been implemented as detailed in this annual governance statement. The Trust's Head of Internal Audit Opinion outlines that BDO are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.

Conclusion

I am satisfied that effective systems of internal control are in place and that the culture of risk management is embedded at Yeovil District Hospital. There are no significant internal control issues which have been identified during the course of the year or in relation to this annual governance statement.

Jonathan Higman, Chief Executive, 25 May 2018

Yeovil Hospital Healthcare

NHS

Yeovil District Hospital NHS Foundation Trust

Quality Account

2017/18

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Part One: Our Commitment to Quality

Statement from the Chief Executive

Welcome to Yeovil District Hospital ('YDH') NHS Foundation Trust's Annual Quality Account for 2017/18.

We are required to produce this document each year to set out our performance against a range of measures, and describe the ways in which we have worked to provide the best care for our patients. It's been another busy year for YDH: 45,376 people were admitted to our hospital, and 50,455 people attended our emergency department (A&E). More than 55,498 x-rays, MRIs, and other diagnostic tests and scans were carried out, and in our maternity unit, 1,463 babies were born. Whilst winter always brings additional demand for NHS services, this winter proved exceptional both for the scale of the challenge, and the response of our staff. We're proud of the way in which our organisation responded to the complexities – including access for staff and patients – posed by the severe weather.

Technology remains a core enabler of care in our hospital, with the continued roll-out of TrakCare - our electronic health record. We have also developed a new partnership with UK-based technology company, DeepMind, which will see us implement the Streams app – mobile software which makes clinical information readily available to staff on mobile devices.

From its launch next year staff will be able to use Streams for vital signs observations, capturing information such as heart rate, blood pressure, respiratory rate, temperature and alertness, which will instantly be available to other Streams users involved in caring for that patient. Later applications will include notifications about deteriorations in patient health, and alerts to the potential presence of serious conditions such as acute kidney injury. Enhancing clinical expertise and experience in this way enables staff to react even more swiftly to ensure the best outcome for patients. Our patients are already benefitting directly from the implementation of new technology through the use of digital check-in kiosks, which are reducing delays for patients arriving for appointments.

We have maintained exceptional operational performance throughout the year, ending the year as one of very few hospitals in the England to meet the four-hour waiting-times target for A&E, and the referral to treatment waiting-times target. We also maintained the lowest rate for hospital-acquired cases of C-Difficile in the South West.

Ensuring a safe and sustainable workforce remains a priority for the organisation, and during the last year the Trust has been thinking globally and working on behalf of other organisations when it comes to the challenge of nurse recruitment. During a visit to Dubai, the YDH team offered posts to just under 700 nurses, who will join the hospital as well as Trusts in Somerset and beyond. At YDH, these new members of our team will help to fill all of our nursing vacancies.

Our work with primary care continues, both through our Symphony Programme (an NHS England Vanguard which is developing new approaches to care in south Somerset) and Symphony Healthcare Services (SHS), our GP-practice operating arm. At the time of writing, SHS practices are caring for around 60,000 patients in Somerset and beyond.

I hope you find this Quality Account an interesting and informative read. Whilst it is not intended to provide an exhaustive account of the quality improvement work undertaken in 2017/18, it does articulate our priorities and some of the ways in which we maintained and improved patient care, safety and outcomes last year.

On behalf of Yeovil District Hospital NHS Foundation Trust, I confirm that to the best of my knowledge the information contained within this report is accurate.

Jonathan Higman
Chief Executive

1. Our Vision and Values

Continuing to provide high quality clinical care and excellent patient experience remains the Trust's top priority. We are proud of our iCARE principles, initially developed by our nursing staff, and which now underpin all that we do within the hospital; whether it is providing a life-saving treatment, how staff relate to one another or a warm welcome at reception. The iCARE principles arose from a review of complaints, which identified common issues and which formed the basis of our values:

i treating our patients and staff as **i**ndividuals
C effective Communication
A positive Attitude
R Respect for patients, carers and staff
E Environment conducive to care and recovery

All staff are introduced to iCARE at the Trust Induction Day, where the expectations and standards outlined by iCARE are shared. In addition, the iCARE principles are included in staff appraisals, in job descriptions and are reiterated in policies procedures and training programmes. The main focus however, is to ensure that these values are evident in our daily work and in our care of patients, their visitors and our staff.

1.2 Our Corporate Objectives

The Trust vision and strategy helps to guide the way the organisation develops. Both the vision and strategy have been developed in collaboration with staff from across the organisation. As well as guiding decision-making, our strategy is also intended to provide staff with opportunities to identify and implement improvements in their own areas of work. During 2017/18, the Trust has revised its vision and objectives to reflect local and system wide priorities.

Our vision: To care for you as if you are one of our family.

This is underpinned by a set of strategic priorities:

- Care for our population
- Develop our people
- Innovate and collaborate
- Develop a sustainable system

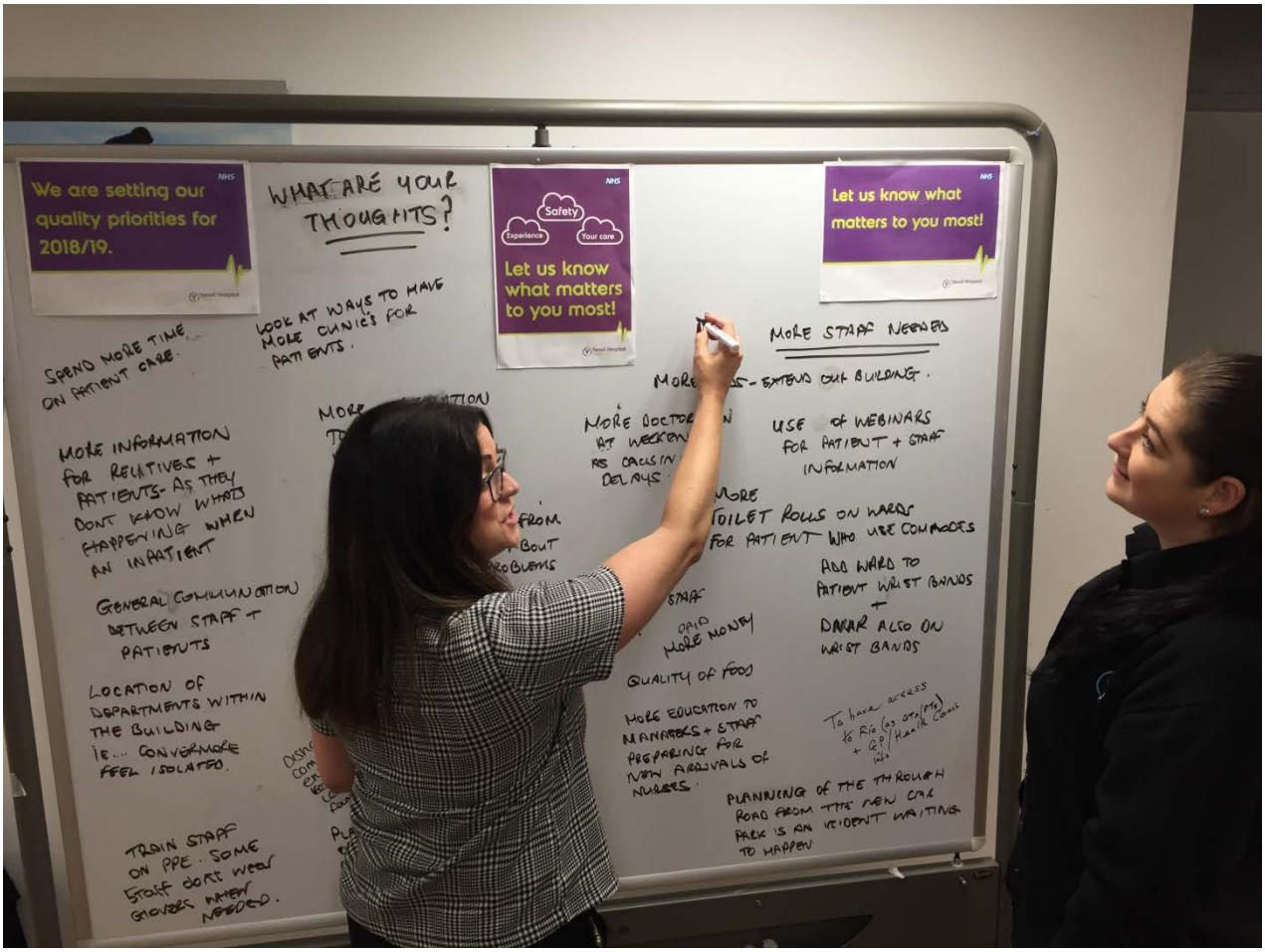
Our strategic objectives are designed to provide focus on quality, sustainability and delivery across all aspects of the organisation and align with our Quality Strategy and Safety Improvement Plan. Our quality priorities are derived from reviews of national reports, local issues and challenges, patient feedback and public engagement events and performance against these, as well as our focus for 2018/19 are outlined in this report.

Part Two: Priorities for Improvement and Statements of Assurance from the Board

2.1 Quality Improvement Priorities

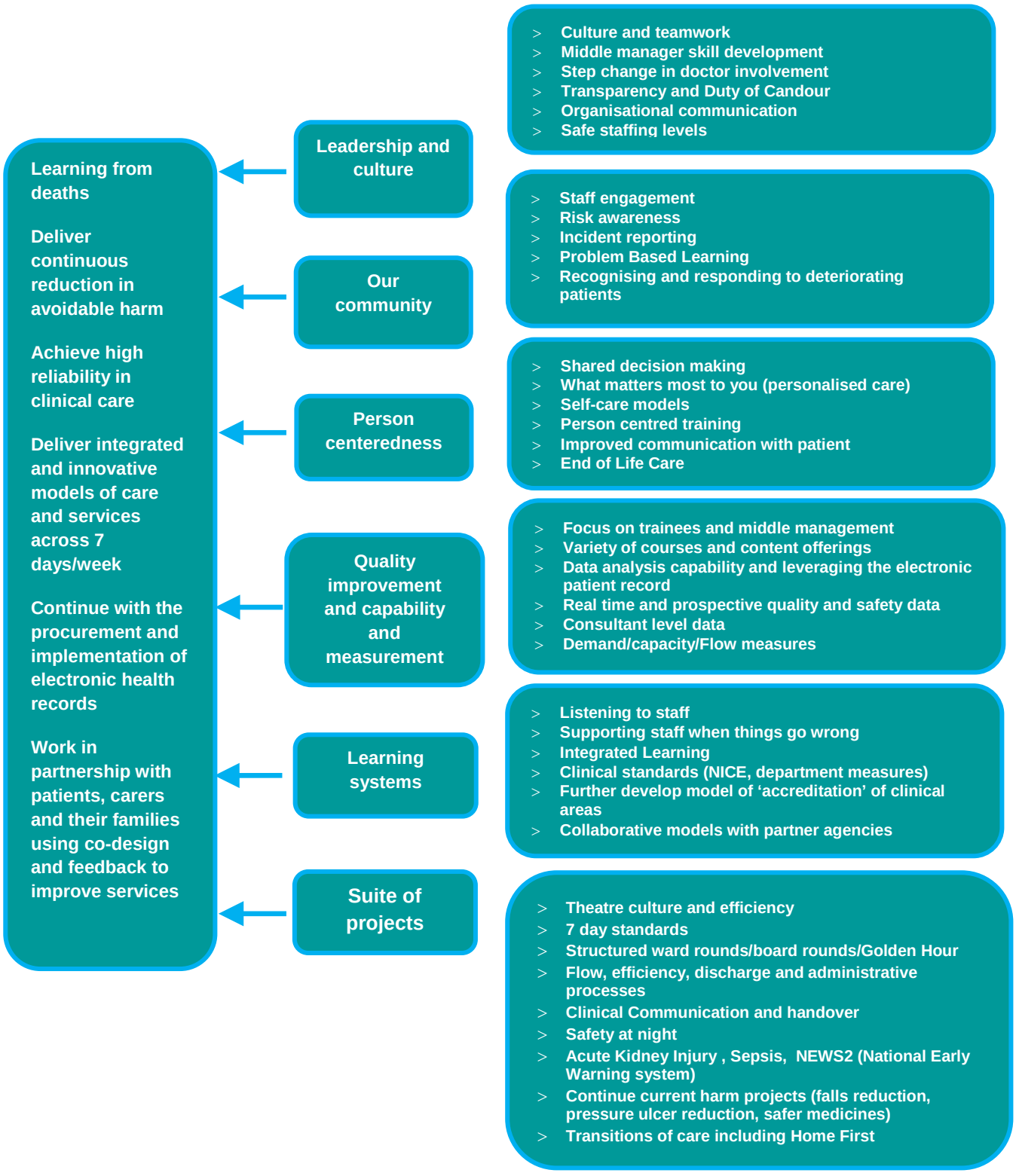
YDH prides itself on keeping the quality of care at the forefront of service delivery and will ensure the safety, experience and effectiveness of care is of the highest possible standard. The Trust has focused its efforts on the delivery of key priorities during 2017/18 and will continue to drive forward improvements in these areas. The data presented and the priorities identified for future focus are applicable to the Trust subsidiaries and associated services including Day Case UK

To identify these priorities we held a number of events to engage with staff, patients and their families including promoting the use of a graffiti wall to capture feedback. Events included participation in National Dying Matters Week, a programme of Health and Wellbeing events, participation in the National Pressure Ulcer Collaborative and participation in a countywide Quality Improvement group.



The Trust utilises Quality Improvement methodology to measure and drive improvements in the experience, safety and effectiveness of care. This approach, devised by the Institute of Healthcare Improvement, is internationally recognised for supporting the delivery of reliable and consistent change and members of staff from across the Trust have been trained to use these techniques to deliver improvements for the benefit of patients, families and staff.

The Trust has adopted this approach to describe its quality aims and drivers to achieve improvement as summarised by the Driver Diagram.



Priorities and summary of performance to date

2017/18	Year-end Achievement
Priority 1	
No preventable deaths as measured by mortality ratios, Serious Incidents that resulted in deaths and mortality reviews.	Our SHMI has remained within the expected range compared to other Trusts. The year-end position was reported as a SHMI of **0.9624** as at September 2017 CRAB observed/expected ratio for deaths following surgery has remained below the normal ratio of 1.0. We implemented standardised use of the Royal College of Physicians Structured Judgement review Tool and developed a policy, in line with national requirements, to ensure learning from deaths is identified and improvements in care delivered as a consequence.
Priority 2	
Deliver continuous reduction in avoidable harm as measured by NHS Safety Thermometer, Never Events, Healthcare Associated Infections (HCAI) rates (including E.coli) Sign up to Safety Campaign Measures for common cause incidents (pressure ulcers, patient falls, medication errors).	The Trust reported 60 pressure ulcers (grade 2 and above) in 2017/18 compared to 85 in 2016/17. This constitutes a 29% reduction over the last year compared. The final position for 2017/18 included all cases identified and did not differentiate between those that might be avoidable or unavoidable compared with previous measures. A total of 800 medication related incidents have been reported for 2017/18 compared to 868 for 2016/17. Of those reported, 25% involved an error that reached the patient. While the majority of these errors caused no harm to the patient, the number of incidents reported as “significant” (led to patient harm or required medical intervention) remained low at 2%. The Trust has continuously maintained its Safety Thermometer results above 95% for new harms with an overall average of 97% for 2017/18. There was one Never Event, a retained guidewire, compared to two wrong site surgery Never Events in 2016/17
Priority 3	
Achieve high reliability in clinical care as measured by compliance with care bundles for: Acute Kidney Injury (AKI), Sepsis, Pressure Ulcer Prevention, Structured ward and board rounds and agreed staffing levels.	For the first three quarters of 2017-2018 we have maintained Commissioning for Quality and Innovation (CQUIN) performance of >90% of relevant Emergency Department patients being screened for Sepsis and those identified as having Red Flag Sepsis having antibiotics administered within 60 minutes. Inpatient screening was also >90% with >87% receiving antibiotics within the 60 minute time frame. Q4 data is currently being compiled and

	additional audit of compliance with the 6 elements of the Sepsis 6 Bundle has now been added to the data. The Trust reported 92% compliance with screening for sepsis in the Emergency Department at year-end.
Priority 4	
Deliver clinical services in line with National Seven Day Standards and measured by national audit participation.	The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. There are ten clinical standards for seven day services in hospitals which were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. 4 core standards have been monitored in 2017/18 with the details outlined later in this report. The Trust has increased the number of services across the 7 day week during 2017/18, including 24 hour/7 day Critical Care Outreach.
Priority 5	
Increase opportunities to engage with patients and their carers to understand what matters to them and plan with them accordingly.	The Patient Experience team appointed a Patient Engagement and Experience Lead to lead on the development and delivery of a Patient and Public Engagement Strategy. This included the development of a calendar of events and Governor initiated surgeries, to increase opportunities for users of our service to provide feedback.
Priority 6	
Patients, carers, staff and members of the public will be treated as equal partners and have confidence that their feedback is being listened to and has improved delivery of services.	The Friends and Family test is captured using an online system called "IwantGreatCare". 'IwantGreatCare' has allowed us to enhance our commitment to listening to patients by improving the way we gather patient feedback. Feedback is captured at ward and department level and feedback provided to staff accordingly. A new electronic complaints system was implemented to improve the timeliness of response.
Priority 7	
Implement digital technologies to support delivery of timely and effective care including implementation and roll out of TrakCare as the Electronic Patient Record across the Trust.	Phase 2 roll out has included: • Access to the GP system EMIS; • Electronic vetting of referrals; • Improved patient flow via Trakcare • Alerting the Symphony Complex Care Team when specific patients present to ED; • Flagging of patients with Learning Difficulties to ensure earlier intervention from our LD Practitioner; • Implementation of Self Check-in Kiosks; • Pharmacy Stock Implementation.

Priorities for 2018/19

In reviewing our priorities and progress against 2017/18 plans, we have considered where further improvement is required and engaged with patients, families and staff to identify areas for particular focus. We also worked with partner organisations across the county to agree a single set of quality priorities for the acute Trusts in Somerset. This has resulted in a number of changes to the quality priorities for 2018/19.

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 Hospital Standardised Mortality Rate (HSMR), Summary Hospital Level Mortality Rate (SHMI), Serious Incidents (SIs), Mortality reviews).
Priority 2 (New)	**Safer Care** Continuous reduction in avoidable harm – (measured by incidence of pressure ulcers, falls, medication incidents, maternity safety metrics, implementation of National Early Warning System 2 (NEWS2) and Streams, compliance with sepsis CQUIN, SI's and Never Events).
Priority 3 (New)	**Mental Health and Holistic Care** Increase staff capability to recognise and respond to those with mental health needs (children, adults in crisis, older people) (measured by training compliance - Conflict resolution, Eating Disorders, Adolescent Mental Health e-learning, number of mental health first aiders, establishment of Psychiatric Liaison pathways).
Priority 4 (New)	**Patient Experience** Improve patient experience using co-design, personalised care planning and family centred care to inform service improvements and care pathways (measured by adoption of 'Always Events' methodology, Complaints, Patient Advice and Liaison Service (PALs) concerns, public engagement events and user engagement in identified work streams).
Priority 5 (New)	**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, improving discharge, Health and Care Strategy work streams, Somerset Quality Improvement (QI) Faculty and Somerset Academy programmes of work).
Priority 6 (New)	**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).

Priorities will be monitored and reported to the Governance and Quality Assurance Committee and Trust Board accordingly.

2.2 Statements of Assurance from the Board

Progress against the 2017/18 key priorities were monitored via a dashboard presented to the Board and in quarterly quality reports to the Clinical Governance Assurance Committee. The following section outlines the indicators, explaining the rationale for their inclusion and year on year progress against the measures. Further information on each of the indicators is included in Part 3 of this Account.

Priority 1: No preventable deaths as measured by Hospital Standardised Mortality Rate (HSMR), Serious Incidents that resulted in deaths, mortality reviews, Care Quality Commission (CQC) mortality alerts

The Trust uses the Copelands Risk Adjusted Barometer (CRAB) to provide outcomes data. The Clinical Outcomes Committee continues to monitor outlier reports and is gaining experience in analysing consultant and specialty level data. The mortality data provided by CRAB also informs the regular mortality and morbidity process.

CRAB analyses data in many ways, using the Trust's clinical coding information and looking at the reasons for a patient's death or readmission. The 'Triggers' are based on information from the Institute of Health Improvement (IHI) Global Trigger Tool and include:

- Lack of National Early Warning Score (NEWS);
- Shock or Cardiac Arrest;
- Nosocomial Pneumonia;
- Rising Urea or Creatinine;
- Unplanned Transfer;
- Positive Blood Culture;
- Return to Theatre;
- Transfer to Higher Level;
- Fall in Haemoglobin.

The monthly CRAB reports highlight areas or groups of patients where activity is outside of the UK norm for that condition. This indicates that there could be a significantly higher than expected mortality, readmission or complication rate. For teams or procedures where a 'trigger' is identified a full review of the medical records for the group of patients allows us to ensure that there have been no underlying problems or failures in care.

In Hospital deaths per month

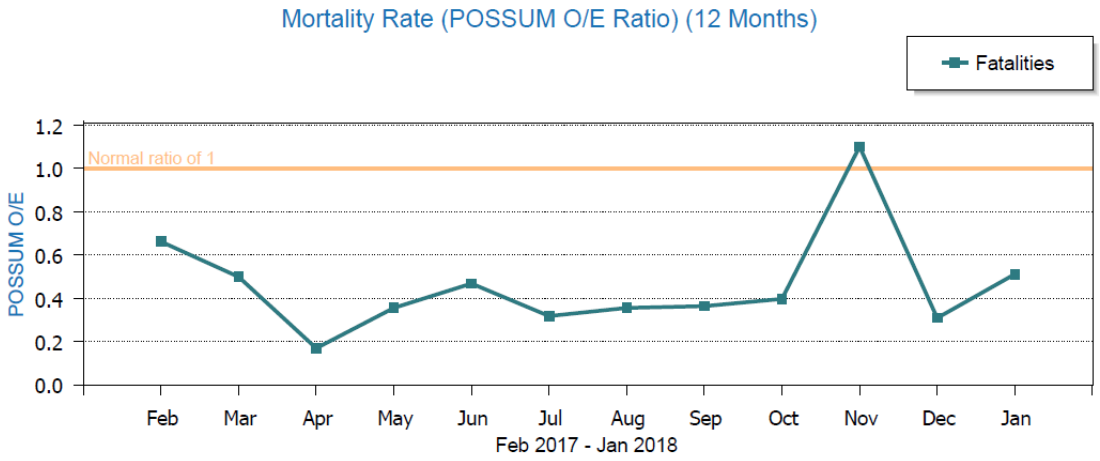
The number of deaths in hospital is captured through the **Summary Hospital-level Mortality Indicator (SHMI).** This reports mortality at trust level using a standard and transparent methodology which is published quarterly as a National Statistic by NHS Digital.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated. Data includes hospital deaths and those occurring 30 days after discharge.

Our latest published SHMI for the timeframe October 2016 – September 2017 is **0.9624** with 1 being the expected norm**.** (The next data release is not due until June 2018).

CRAB data also defines the risk of mortality within certain groups of patients.
The following table shows risk adjusted mortality data over the last year in patients who have undergone surgery.

Risk Adjusted Mortality



The normal mortality O/E (Observed number of adverse outcomes / predicted number of adverse outcomes) ratio is 1.00. The Trust has remained below this acceptable norm throughout the year. Drilling down into this data allows the Trust to identify any adverse outcomes and look at these in relation to volume of procedures performed.

Hospital Standardised Mortality Rate

The Trust HSMR is reported at 114.0 at the time of reporting and above expected range. Analysis has not identified any problems in care however, a number of actions have been taken to provide assurance of the safety and quality of care and to make improvements accordingly. Actions include:

- Improved accuracy of clinical coding of patients being managed on a palliative care pathway;
- Audit of patients with a primary diagnosis of urinary tract infection who have died;
- Audit of patients with a primary diagnosis of anaemia and haemorrhage;
- Introduction of a combined Treatment Escalation Plan/Do Not Attempt Resuscitation (TEPDNAR) document for all emergency admissions to improve and inform clinical management plans;
- Increased focus on early conversations with patients and/or their families about wishes and ceilings of treatment if thought to be in the last year of life;
- Improved recording and coding of AKI in patients failing to respond to primary care treatment by the GP for urinary tract infections.

It is anticipated that the HSMR will reduce early in 2018/19 as a consequence of these actions.

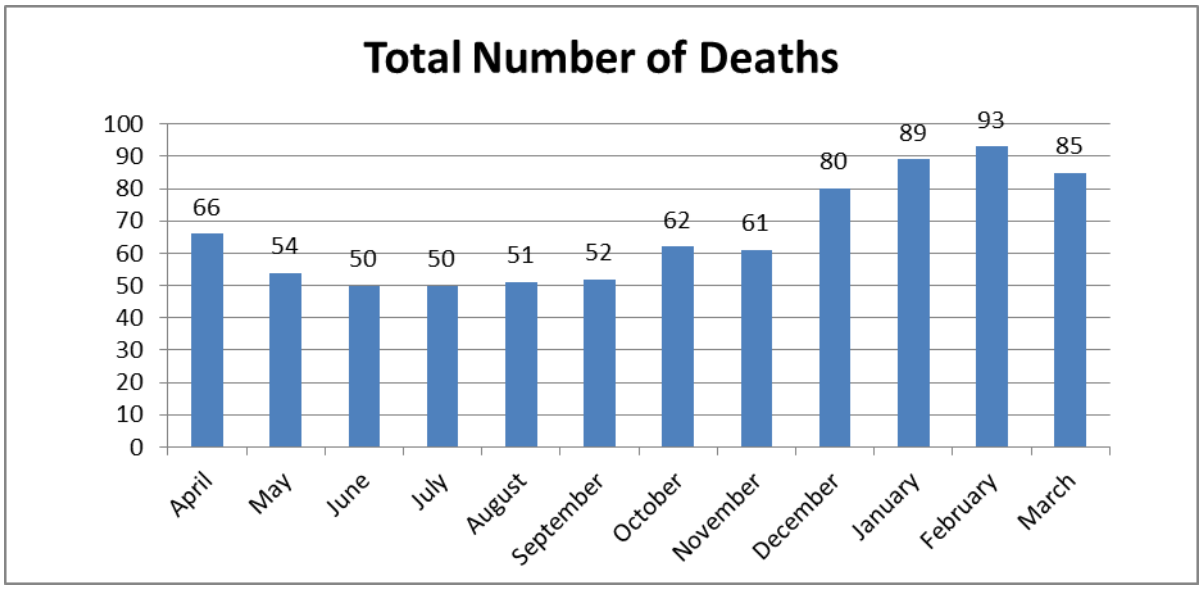
In 2018, the Trust received a CQC Outlier alert in relation to deaths attributed to urinary tract infection. A clinical audit and case review was undertaken which confirmed no deaths attributed to care concerns but did identify opportunities to improve medical record keeping and accurate recording of AKI.

An action plan has been drafted to ensure appropriate oversight and to provide assurance of the improvements planned and consequent impact. This will be monitored by the Clinical Outcomes Committee on an ongoing basis.

Learning from Deaths

The National Quality Board published 'Guidance on Learning from Deaths' in March, 2017 and introduced enhanced reporting of case note mortality reviews. Focus across the country has been on standardising the review of deaths using a structured judgement review (SJR) tool developed by the Royal College of Physicians. This tool has been adopted throughout the Trust, with formal mortality reviews recorded on a central data base to enable learning to take place across all areas of the Trust. Data is published quarterly highlighting the total number of deaths and the number of these patients who have been subject to an investigation as a result of a Significant Untoward Incident, a complaint, a bereavement concern, a Learning Disability death (LeDer) review or formal mortality review using the Structured Judgement Tool.

The following graph shows the number of deaths by month and demonstrates national and seasonal trends

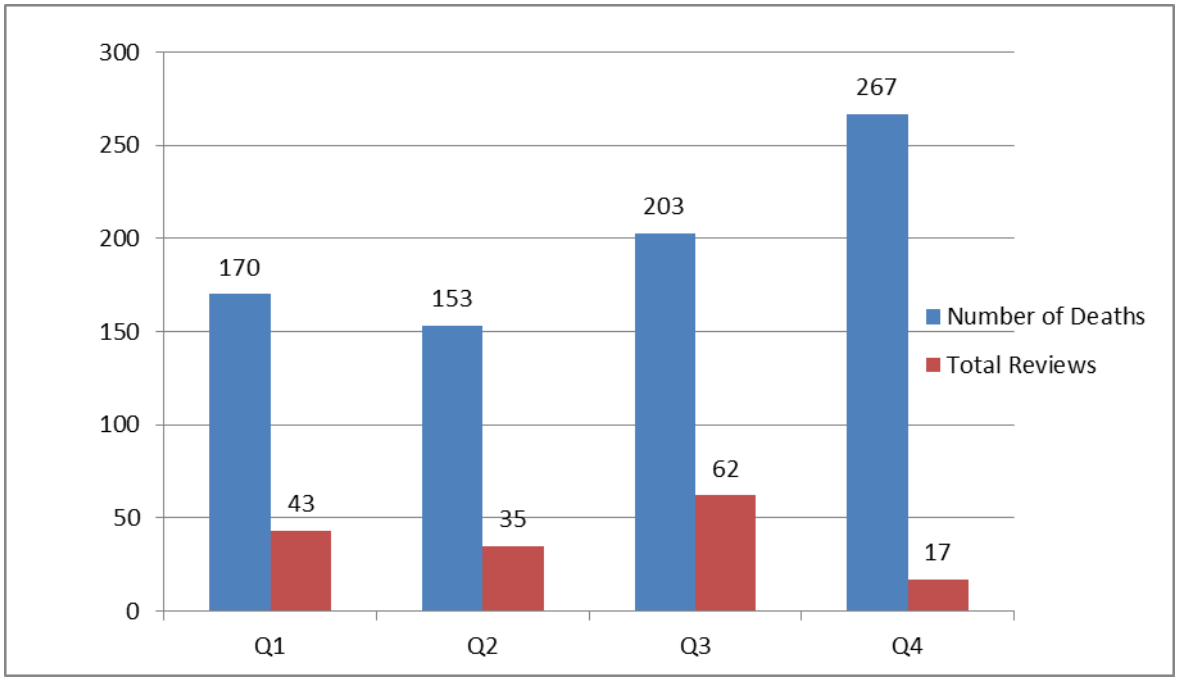


During 2017/18 a total of 794 of Yeovil District Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Period	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year End
No. of deaths	170	153	204	267	794
No. subject to review	43	35	62	17	157
No. judged to be more likely than not to have been due to problems in the care*	1	1	2	0	4
% of deaths in the reporting period judged as more likely than not to be due to problems in care	0.58%	0.65%	0.98%	0%	0.50%

*This number has been calculated according to the scale contained within the Structured Judgement Review Tool and includes all cases rated 1-3 and 1 Serious Incident.

By 31 March 2018 135 case record reviews and 22 investigations have been carried out in relation to 157 of deaths. In no cases was a death subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out is outlined below:



Cases were reviewed using the Structured Judgement Review tool (SJR) from the Royal College of Physicians, or via the Trust's Serious Untoward Incident process. The SJR enables clinicians to assess the management of each case and identify a level of potential avoidability based on the actions taken and the care provided for each individual case. This is a subjective judgement but is based on the clinical best practice for the given situation. The SJR has been adopted throughout the Trust to ensure that formal Mortality reviews are undertaken and that this data is available to inform improvements in care and reporting to the Board.

The SJR uses a scale to determine whether care concerns were a contributing factor. The scale is as follows:

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

A number of cases are reviewed via speciality Morbidity and Mortality meetings on a monthly basis. These cases are presented at the local Clinical Governance Meetings to share findings and inform improvements in care delivery.

In addition the monthly Mortality Review Group reviews cases where a potential problem in care has been identified and those deaths flagged with four or more triggers identified by CRAB. The Mortality Review Group provides assurance to the Clinical Outcomes Committee which also monitors the outlier reports produced by CRAB. This ensures any issues are identified and enables trust wide learning for improvement.

Serious Untoward Incidents are investigated using methodology based on NHS England's Serious Incident Framework and using the definition of what constitutes a reportable serious incident.

Learning from Mortality reviews and Serious Untoward incidents throughout the year 2017/18 included;

- The positive impact of active and timely discussion with patients and their families on treatment escalation and resuscitation status. This links with an increased use of TEPDNAR both within the Trust and in partnership with the community;
- The importance of early recognition of chronic conditions such as pancytopenia and presenting complaints to ensure timely diagnosis and treatment;
- Early catheterisation and accurate fluid balance monitoring in patients with AKI and the impact this has on the management and resolution of this common condition;
- An excellent standard of record keeping in Cardiology;
- Early involvement and review of leg ulcers by the Tissue Viability Team and identification of sepsis risk factors in the prevention of deterioration in patients with chronic tissue damage;
- Early involvement of the Palliative Care Team in discussions with families.

The actions taken in respect of the learning over the review period included;

- Discussion of cases at local Governance Meetings to inform decision making and learning;
- Monthly audit in place of the use and accuracy of TEPDNAR orders with the results being monitored at the Recognition and Rescue Group;
- Education and monitoring of the implementation of AKI Care Bundle to ensure timely intervention and appropriate management for patients admitted with or developing AKI;
- Re-education and modification of fluid balance charts and implementation using Quality Improvement Methodology to ensure effectiveness and facilitate changes as rolled out from ward to ward;
- Shared the positive aspects of the mortality reviews to provide benchmark for other specialties;
- Monitoring of the use of the Sepsis Care Bundle to ensure accurate identification and recognition of this condition as well as appropriate management once detected;
- Changes to Last Days of Life Communication Pack based on National Institute for Health and Care Excellence (NICE) guidance to improve the quality of documentation and aid symptom relief for all patients at the end of life. This came from a Quality Improvement project using a comprehensive observation chart to facilitate holistic care to the patient.

The actions taken have resulted in;

- Planned introduction of county wide documentation and improved agreements across health care settings;
- Improved compliance with detection of AKI with or without use of the care bundle;
- Improved fluid balance charts with better compliance with completion of the document rolled out to ward areas using a Quality Improvement methodology with small steps of change;
- Raised awareness and increased use of the Sepsis Care Bundle and continued audit of compliance with treatment within the crucial timespan. Increased numbers of patients using care bundle;
- Improvements and reintroduction of the End of Life Communication Tool, standardising and reinforcing proactive recognition and symptom control. This chart should be used for all patients nearing the end of life at the discretion of the overseeing medical team. Continuous monitoring is in place to ensure improvements are sustained.

No case record reviews or investigations were completed after 31 March 2017 which related to deaths which took place before the start of the reporting period.

The Coroner can also ask for an investigation relating to the death of a patient. The coroner`s role is to establish the cause of death and ensure that any failure or omission in the management and care of the patient has not contributed to their death.

Priority 2: Deliver continuous reduction in avoidable harm as measured by NHS Safety Thermometer, Never Events, Healthcare Associated infection (HCAI) rates (including E.coli) and common cause incidents (pressure ulcers, falls, medication errors)

Safety Thermometer

Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other measures of harm to measure progress in providing a care environment free of harm for our patients.

The NHS Safety Thermometer allows the Trust to measure harm and the proportion of patients that are 'harm free'. Patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps us to measure, assess, learn and improve the safety of the care we provide. The Safety Thermometer allows us to check how many patients in our care have suffered one or more of a defined list of "harms" associated with patient safety. These harms include pressure ulcers and falls. The Safety Thermometer also records if a patient has had a catheter associated urinary tract infection, if they have a Venous Thrombo-embolism (VTE) and if they have been given prophylaxis. The Trust has maintained its Safety Thermometer results above 95% throughout the reporting period with 97% of patients being recorded as harm free in April 2017 and 98% in March 2018. This is an overall average of 97% for the year.

Ward 10 and Maternity use a different Safety Thermometer tool which produces a 'Harm Free' score only. Maternity maintained a consistent 100% throughout the year. Ward 10 had an overall average score of 81%. The unit has less beds therefore any 'harm' scored will have a significant impact on the overall figure.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Yeovil District Hospital adheres to the National Patient Safety Agency (NPSA) guidance on the reporting and management of Serious Incidents Requiring Investigation, including Never Events, and the structure and process of a full root cause analysis, as set out in the National Patient Safety Agency guidance, is applied to each case.

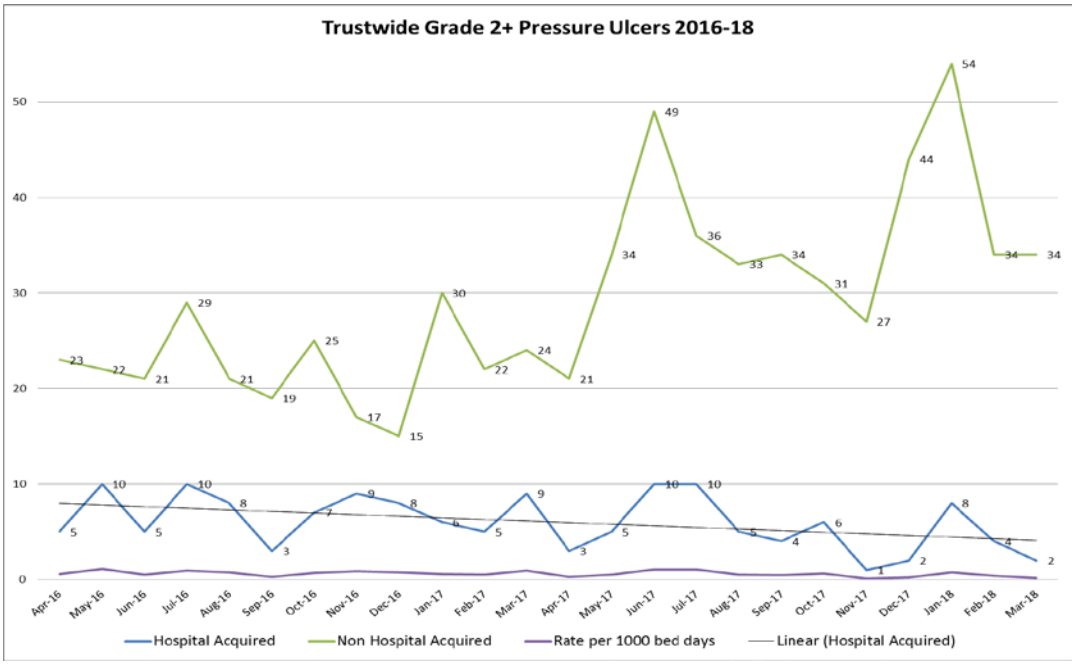
The Trust reported one Never Event during 2017/18 in relation to retained object post procedure - a PICC line guidewire was left in situ for 4 days. A full formal investigation identified all relevant learning and actions to prevent similar occurrences. The principles of National Safety Standards in Invasive Surgical Procedures (NatSSIP's) are currently being worked through across the Trust with those procedures relevant identified and policies and procedures relating to specific Local Safety Standards for invasive surgical procedures (LocSSIP's) being embedded in routine clinical practice where relevant. As a result work is underway with the Day Theatre and Surgical teams on increasing understanding of human and contributory factors and use of standardised processes to ensure patient safety.

Pressure Ulcer Prevention

As a sign of our ongoing commitment to reduce hospital acquired Pressure Ulcers, we continue to monitor and report our position on hospital acquired (Grade 2 and above). Preventative actions are a key focus in driving improvement and factor within assessment and ongoing care planning. The improvement work is led by the Pressure Ulcer Steering Group which reports to the Patient Safety Steering Group.

The Trust participated in an NHSI Pressure Ulcer Collaborative, which focused on 2 clinical areas for improvement in pressure ulcer prevention. As a result, a number of interventions including enhanced education, use of visual aids and early clinical review, led to a further reduction in hospital acquired pressure ulcers and will be implemented trust wide.

At the end of the year, a total of 60 hospital acquired pressures ulcers (Grade 2 and above) were reported compared to 85 for 2016/17. This equates to a 29% reduction.



Reducing Patient Falls

Some patients are at high risk of falling, either as a result of their rehabilitation or condition, and it is recognised that this causes anxiety, loss of confidence and in some cases serious injury to patients. The length of stay for patients who have fallen whilst in hospital is often increased as staff attempt to improve their mobility and confidence.

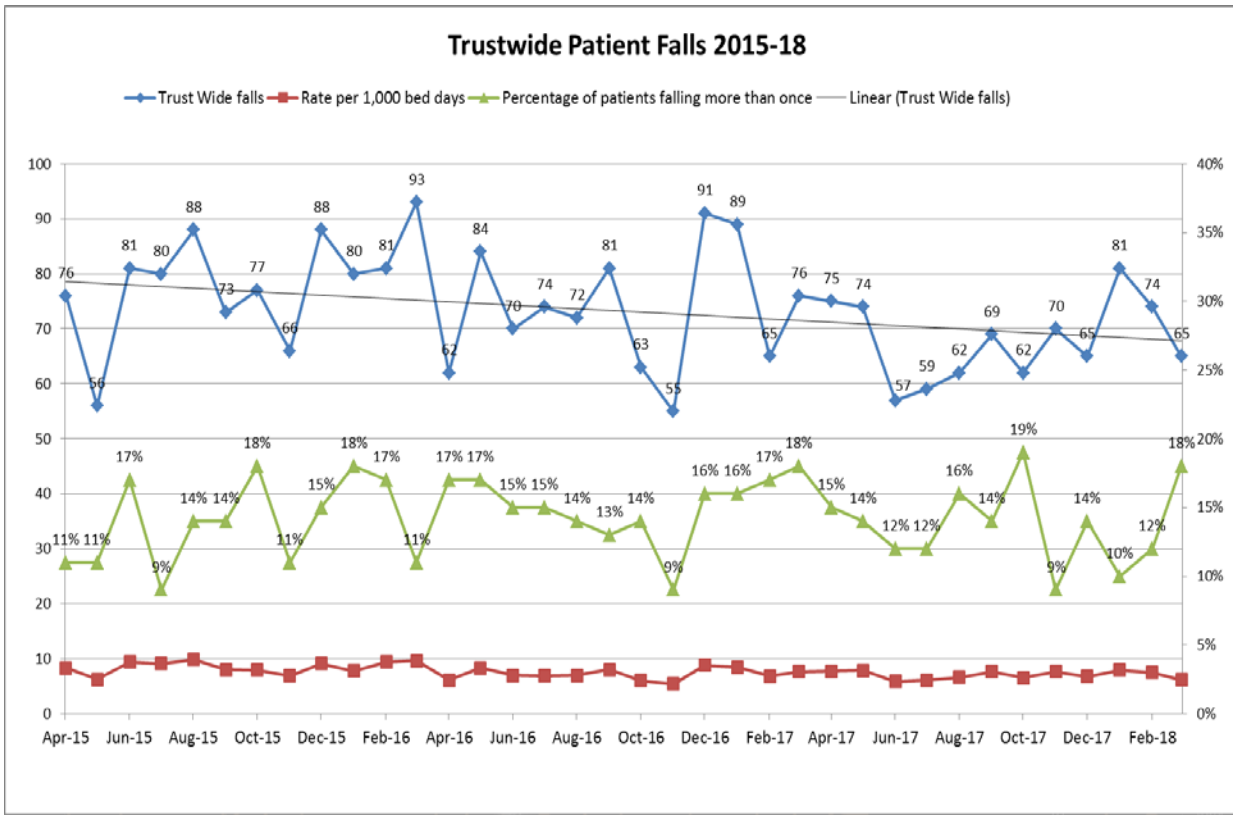
The Falls Coordinator has now been established in post for over a year. This role has increased our ability to work with partner organisations and improved the response to areas of concern. Continued training has been provided using the Snack box approach and has been well received.

Tag Care continues to be used and has become embedded in ward practice, forming part of the daily ward risk assessment.

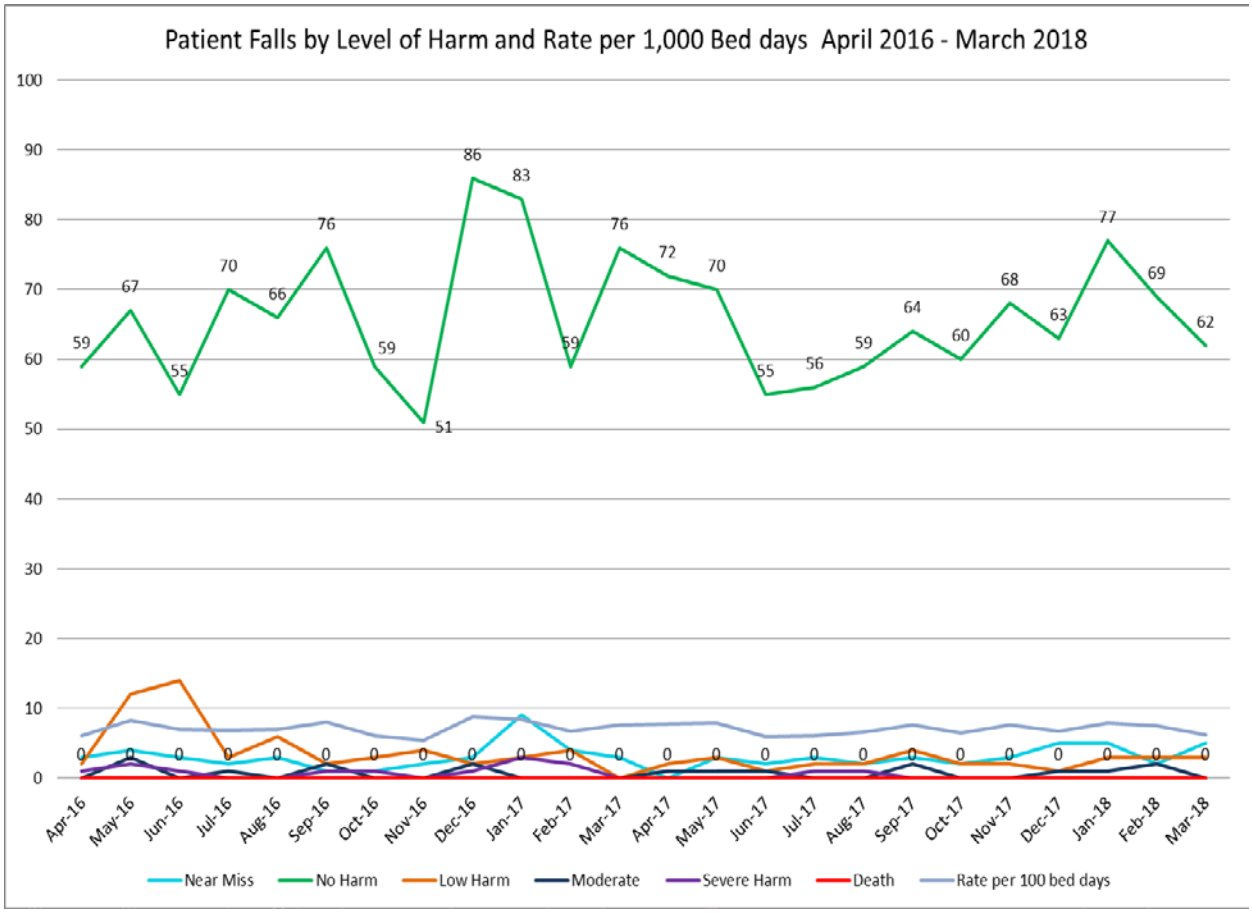
We received the results of our latest National Audit of Inpatient Falls which have informed the basis of our falls work plan for 2018/19. Our success will be measured by an internal re-audit in January 2019.

The data detailed is extrapolated from the Trust Local Risk Management System (LRMS) which captures all reported incidents of slips, trips and falls. Definitions are in line with national guidance. Data is uploaded to the National Reporting and Learning System (NRLS) twice a month.

Overall the number of falls has reduced over the year with the final number for 2017/18 reported as 813 compared with 882 the previous year. This equates to a 7.8% reduction.



Levels of Harm are calculated using the National Patient Safety Agency (NPSA) risk matrix and in accordance with national guidance. Data is extrapolated from the LRMS and reported as incidence and rate of falls per 1,000 bed days as detailed below. The rate per 1,000 bed days for 2017/18 was 7.01 which compares to 7.2 for 2016/17.



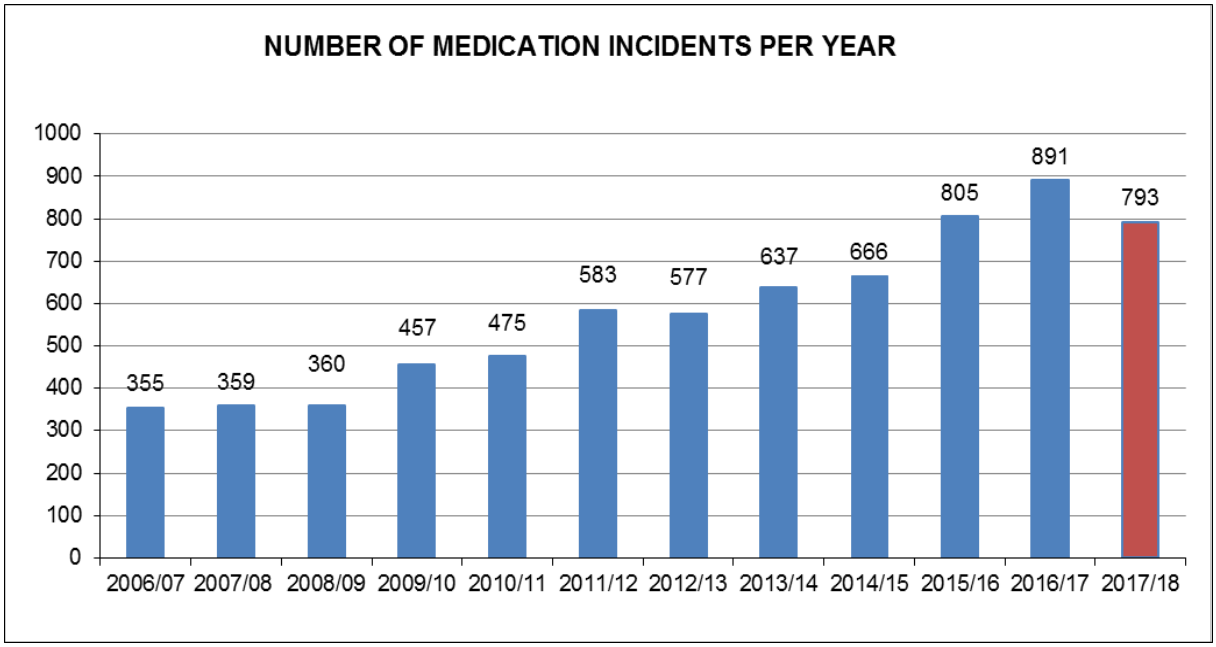
Safer Medicines

The Trust aims to provide the best possible medicines optimisation and is working together with patients to deliver safer and better outcomes from medicines. We collect meaningful data regarding medication incidents, missed doses, allergy status, medicines reconciliation and high INRs with warfarin. We continue to produce Medication Safety Bulletins which focus on identified risks, with examples of real incidents and clear actions for each healthcare group.

Of the 800 medication incidents reported over the last 12 months, 25% reached the patient. While the majority of these errors caused no harm to the patient, the number of incidents reported as “significant” (led to patient harm or required medical intervention) remained low at 2% of the total number of reported medication incidents.

The Trust encourages staff members to report all incidents, including those of no harm, to ensure a high level of safety awareness is maintained and to enhance our understanding and learning from near misses.

Although the number of medication incidents reported by YDH staff has reduced slightly, the figures remain high during 2017/18 as staff groups are encouraged to report all incidents to enhance our understanding and learning.



The number of medication incidents linked to patient harm (or requiring medical intervention) remains low at 1.6%. This compares favourably with data from 2016/17 which shows that 4.6% of all reported medication incidents were linked to patient harm (or required medical intervention).

The Trust's Safer Medicines Group continues to monitor all medication related incidents, Drug Safety Updates and relevant medication Patient Safety Alerts. The group is also responsible for implementing changes to the prescribing, administration and handling of medicines within the Trust in order to minimise risk and to improve patient safety. Following a recent review of Trust medication groups, it has been agreed to merge the Drug and Therapeutics Committee with the Safer Medicines Group. This new committee will be known as the Medicines Committee, and will provide more emphasis on the safety, quality and assurance of medicines used within the Trust.

Trust incident reports of high risk medicines (anticoagulants, methotrexate, insulin and gentamicin) will continue to be scrutinised by this committee. Several Medication Safety Bulletins have been published over the last 12 months following reported incidents. These have included bulletins produced to raise awareness of safe prescribing of both methotrexate and intravenous paracetamol. Medication incident reports for these high risk medicines have since been monitored and show a continued reduction in numbers.

Priority 3: Achieve high reliability in clinical care as measured by compliance with care bundles for: Acute Kidney Injury, Sepsis, Structured ward and board rounds, Agreed Staffing levels

Acute Kidney Injury

The Trust recognised an increase in the percentage of key items relating to AKI being completed in patient discharge summaries from 49% in April 2017 to 70% in March 2018, giving an overall average for the year of 63%. AKI is a key priority for the Trust and work in this area is supported by the Recognition and Rescue Group which champions the early recognition and treatment of patients with community and hospital acquired AKI. The Recognition and Rescue group develops, implements, and monitors work streams relating to the recognition and rescue of patients by promoting a culture within Yeovil District Hospital NHS Foundation Trust that focuses on all aspects of Patient Safety Improvement. The group works hard to help staff improve the recognition and management of the deteriorating patient. It also provides a forum to implement improvement methodologies for Recognition and Rescue and ensuring the safety and efficacy of patient care is secured. Work to improve rates of AKI include the implementation and use of a care bundle, a quality improvement project to improve the design, and subsequent recording, of

fluid balance charts, participation in Nutrition and Hydration Week and agreement to trial innovative products to improve oral hydration across the Trust.

Sepsis

An estimated 44,000 people a year die from Sepsis in the UK – with prompt recognition and treatment using the Sepsis 6 as treatment of Red Flag Sepsis around 1/3 of these deaths could be prevented, for YDH this could be 2-3 patients a week. However, this is only part of the story - over 120,000 people in the UK develop Sepsis a year. Most of these will survive, but many will be left with debilitating physical and psychological long term problems. Our continued aim is to reduce Sepsis Morbidity and Mortality through improving screening and recognition of Sepsis and ensuring prompt treatment is given using the Sepsis 6 for those patients identified as having Red Flag Sepsis.

Four Sepsis Screening and Action Tools (Under 5 yrs, 5-11yrs, >12 yrs (Adult) and Maternal) have been implemented and have now become embedded across all areas of YDH. Monthly audits of compliance with Sepsis Screening for Emergency Department patients and inpatients; and treatment of sepsis with intravenous antibiotics within 60 minutes of diagnosis take place with quarterly results consistently >85% for Q1-Q3 2017-18. In Q4 we are now recording compliance with each of the elements of the Sepsis 6 in the management of Red Flag Sepsis.

	2a (i) ED Screening (adult/Paed)	2b (i) Inpatient Screening	2a (ii) ED Antibiotic Admin and Review	2b (ii) Inpatient Antibiotic Admin and Review
Quarter 1				
April	67% (84.8%/50%)	developing data col	18/45 = 40%	No inpatient sepsis identified in cohort of notes
May	88% (75.5%/100%)		27/54 = 50%	
June	90% (80%/100%)		18/45 = 40%	
Q1 Average	82%		43%	
Quarter 2				
July	84% (100%/82%)	7/9 = 78%	21/27 - 78%	2/2 = 100%
August	88% (87.5%/100%)	7/11 = 63%	12/21 = 57%	3/3 = 100%
September	100% (100%/100%)	6/6 = 100%	21/33 - 63%	1/1 = 100%
Q2 Average	90.70%	80.30%	66%	100%
Quarter 3				
October	94% (92.5%/100%)	8/9 = 88%	27/39 = 69%	0/0
November	92% (90%/100%)	5/5 = 100%	21/30= 70%	0/0
December	92% (89%/100%)	6/6 = 100%	27/42 = 64.%	2/1 = 100%
Q 3 Average	92.70%	96%	68%	100%
Quarter 4				
January	83.75% (87.5%/80%)	5/6 = 83%	12/21 = 57%	3/3 = 100%
February	88% (89%/85%)	8/8 = 100% (Paed 1/	12/15= 80%	0/0
March	88% (86%/93%)	16/16 = 100%	18/24 = 75%	0/0
Q4 Average	83.67%	94.30%	71%	100%
2016/2017 Average	87.26%	90.21%	62%	100%

Sepsis continues to be significant area of focus and the profile of Sepsis is kept high across the Trust in a number of ways:

- Sepsis simulation training is taking place regularly across wards and departments which has been very well evaluated;
- A public awareness campaign including posters, use of social media and patient's stories;
- Implementation of Doctors' trolleys on each ward with a bright orange sepsis drawer with the contents stocked specifically to improve the speed of management of sepsis;

- Sepsis Star badges and certificates are awarded to staff who have proven to be instrumental in the delivering of the Sepsis 6 within 60 minutes. Using this simple positive feedback has generated a real eagerness for staff to deliver the treatment required in a timely manner for the benefit of the patients. (YDH is now supplying Sepsis Stars to 12 other NHS Trusts in England);
- For the third year running Yeovil Hospital entered a team in the Cycle4Sepsis – this time cycling from YDH to Birmingham to raise awareness of the condition and to fundraise for the UK Sepsis Trust from whom we get all of our information cards and leaflets for patients and relatives;
- The Trust are active members of the Somerset Sepsis Working Group with colleagues from across the county in primary and secondary care, and also link regionally and nationally by way of the South West Sepsis Forum and the national Sepsis Practitioner Forum, and the South West Academic Health Science Network (AHSN).

For 2018/19 a priority is our work with Trakcare and the Digital Transformation Team to develop electronic sepsis screening and electronic patient observations using the new National Early Warning Score (NEWS2). The aim is to develop a reliable and consistent approach to recognition and response to sepsis wherever is required within the organisation.

Ward/Board Rounds

This initiative aims to improve communication and Multi-Disciplinary Team working to improve the patient journey. Nursing, pharmacy, therapy and medical staff meet together daily to discuss the management of all patients on a ward. This enables all staff to plan together, highlighting patient safety issues and prioritising the workload. Standardisation and roll out across the Trust is now complete. To further enhance our board rounds we have implemented the use of red and green days. This allows the multidisciplinary team to discuss each patient and ensure there are no delays that result in the patient waiting unnecessarily for an investigation, consultant review or decision. We have introduced a 'huddle' mid-way through the afternoon to ensure all actions identified in the morning's board round have been completed. This allows time for escalation to relevant person to ensure patients are receiving their required treatment.

Formal consultant ward rounds are part of this initiative. There is consultant presence every day on the majority of wards to ensure patients have access to a senior review or decision. This initiative provides additional support to our junior doctors and supports compliance with national seven day services standards.

Safe Staffing

In 2013 the National Quality Board set out 10 key expectations that have provided the Trust with a framework with regards to safer staffing. In July 2016 the National Quality Board published a document to build on this guidance and to support the Five Year Forward View of planning and delivering services in ways that improve quality and reduce avoidable costs underpinned by the following two principles:

- A specific piece of work has been undertaken with junior doctors to improve staffing levels;
- Access to clinical support services and processes for handover to address areas for improvement.

Right Care - Doing the right thing the first time in the right setting and ensure that patients get the care that is right for them avoiding unnecessary complications and longer stays in hospital and helping them recover as soon as possible.

Minimising Avoidable Harm - A relentless focus on quality based on understanding the drivers and human factors involved in delivering high quality care, will reduce avoidable harm, prevent the unnecessary cost of treating that harm and reduce costs associated with litigation.

Maximising the Value of Available Resources - Providing high quality care to everyone who uses health and care services requires organisation and health economies to use the resources in the most efficient way for the benefit of their community.

In addition, the Lord Carter Report (2016) and the NHS Five Year Forward View Planning Guidance (2014) make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. Lord Carter's report recommended a new metric, care hours per patient day (CHPPD), which the Trust now reports on monthly.

Carter also recommended a development of a model hospital so that Trusts could learn what 'good' looks like from other Trusts and adopt their best practice. Dashboard data is being used to inform the focus on improvement.

As a Trust we are required to ensure that there is sufficient sustainable staffing capacity and capability to provide safe and effective care to patients at all times. All registered nurses, new to the organisation and without recent acute care experience, or those that feel they would benefit from attending, undergo a formal supported induction programme over four weeks, which includes both taught and supervised clinical practice. Unregistered nurses are required to achieve the Care Certificate and undergo a two week supported induction programme, including supervised clinical practice.

Nursing staff are deployed in ways that ensure that patients receive the right care first time in the right setting, with all wards using an e-rostering system which ensures flexible working to meet patients' needs and making best use of resources across the 24 hour period. Allocation of staff is considered accordingly to the acuity of the patients, staffing levels and skill mix of registered and unregistered staff. Where necessary the Trust uses a Ward Risk Matrix and Professional Judgement Tool to further inform staffing decisions.

The Safe Care Module, a functionality of e-roster which allows the Trust to review patient acuity and dependency, is currently being implemented. This is used together with Care Hours Per Patient Day (CHPPD) reports to provide assurance that staffing levels are safe.

Particular attention has been paid to working with junior doctors to improve staffing levels and senior supervision and support out of hours. Increases in junior, middle grade and consultant posts have taken place throughout the year. Extensions to hours of consultant cover in the Emergency Department, 7 day phlebotomy and Assistant Practitioner support are in place and there was an increase in cover from the Critical Care Outreach Team to provide clinical support 24 hours a day, 7 days a week.

The organisation is committed to investing in new roles and has been successful in being a Fast Follower for the Nursing Associate pilot with candidates who commenced in post April 2017.

Priority 4: Deliver clinical services in line with National Seven Day Standards and measured by national audit participation.

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

There are ten clinical standards for seven day services in hospitals which were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

With the support of the AoMRC, four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review;
- Standard 5 – Access to diagnostic tests;
- Standard 6 – Access to consultant-directed interventions;
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others.

27 trusts across England were early adopters of the four priority clinical standards and were working towards implementing the standards by April 2017. Yeovil District Hospital was in the second wave of implementation and has been working towards achieving the four priority standards by April 2018. All trusts are expected to meet the priority standards by 2020. This will ensure patients:

- don't wait longer than 14 hours to initial consultant review;
- get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour;
- get access to specialist, consultant-directed interventions;
- with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds.

Standard 2 is the only standard measured across the year as follows:

	Survey		
	September 2016	**March 2017**	**September 2017**
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	92%	89%	70%

Note: Methodology changes between September 2016 and March 2017 mean that data may not be 100% comparable between the two surveys. The changes relate to the validation of data entered – the 2017 survey requires each entry that has a validation error to be corrected before it is possible to submit the record.

Work that has been undertaken:

- implementing a second ward round in surgery;
- CT and MRI providing 7 day service;
- Access to all diagnostic and emergency interventions 24 hours a day/7 days a week;
- Critical Care Outreach service now available 24 hours a day/7 days a week;
- Combination of daily ward rounds and golden hour to ensure that patients have access to senior doctor review every day

A further audit of all 4 core standards will be undertaken early in 2018/19 to measure year-end performance and inform Trust actions to improve.

Priority 5: Increase opportunities to engage with patients and their carers to understand what matters to them and plan with them accordingly.

The appointment of the Patient Experience and Engagement Lead has provided a valuable opportunity for the Trust to engage with partner organisations in the local community to gain insight and feedback from the local population. We have ensured representation at the Somerset CCG Engagement and Advisory Group, Somerset Carers Voice group, Somerset Gypsy and Traveller Forum, Equality and Diversity Forum, Learners Engagement for Patient Flow, Sparks Talking Café, Autism and Learning Disabilities workshop, Deep Minds Launch Forum.

The Patient Experience and Engagement Lead produced a calendar of events, which includes all community support groups and support within the trust. Patient Experience and Engagement Lead is planning Ester café event training over the next couple of months, so that we can launch this with our staff. The Patient Experience and Engagement Lead is working closely with the Dementia Consultant to relaunch the carer's packages. So far it has been agreed that we will give carers a £2 meal voucher towards the cost of their meal. This will be recorded by a serial number, so this can be monitored. It has also been agreed to give parking concessions to carers, in the same way we do at present. The Patient Experience and Engagement Lead is working on all national surveys across the Trust and action plans are in place and they are being updated regularly. Snap surveys are being completed where there is a need to help with the results of the national surveys. The Patient Experience and Engagement Lead helped co-ordinate the nursing home training day. This included inviting care home staff and setting up the itinerary for the day.

The Patient Voice group provides an opportunity for the organisation to test the learning and actions arising from complaints. The Chairman works closely with the Patient Experience and Engagement Manager to agree monthly observations and audit. Information from these observations has provided valuable feedback from patients regarding the quality of discharges from hospital.

Priority 6: Patients, carers, staff and members of the public will be treated as equal partners and have confidence that their feedback is being listened to and has improved delivery of services.

The Friends and Family test is captured using an online system called "IwantGreatCare". 'IwantGreatCare' allows us to enhance our commitment to listening to patients by improving the way we gather patient feedback. Feedback is captured at ward and department level and the new system has enabled staff to capture feedback at individual clinic level. The feedback will be utilised to provide consultant level information and to inform revalidation.

The number of patients who submitted a feedback survey has increased over the year from 783 in April 2017 to 1288 in March 2018. A total of 15,386 surveys were completed over the course of the year with the year-end average of 95% patients likely to recommend the Trust to family and friends.

The continued development of 'IwantGreatCare' has enhanced our commitment to listening to patients and improved the way we gather patient feedback to inform service delivery.

Actions from complaints are identified and where appropriate an action plan is included with the complaint response to provide assurance to complainants that by making a complaint, improvements have been identified. These actions are included in the relevant ward action plans which are monitored by the Ward Sister and Matrons to ensure compliance. These actions are presented to the Patient Experience and Engagement Steering Group and are considered at the trust-wide Integrated Learning forum to ensure actions are taken to improve patient experience and delivery of services.

All closed action plans from complaints are shared at the Integrated Learning Forum. Themes and trends are identified across incidents, mortality reviews and complaints and as a result a number of actions have been agreed:

- Patient Voice to undertake an audit of discharge arrangements on the wards with the patients/carers themselves to ascertain how much had been communicated, did they understand their arrangements and feel they had been adequately involved;
- A thematic review into concerns raised about discharge and to inform a quality improvement project;
- A deep dive exercise into concerns raised about communication/values and behaviour issues to identify any training requirements;
- Customer Care Training, based on iCARE values, for all staff;

- Advanced Communication Training for senior medical and nursing staff who have difficult conversations or deliver bad news.

Priority 7: Implement digital technologies to support delivery of timely and effective care including implementation and roll out of TrakCare as the Electronic Patient Record across the Trust.

The Trust has achieved the first phase of implementation of a new electronic patient system, Trakcare, which went live in June 2016. This represents a significant change in record keeping and will impact on every department across the Trust. By the end of March 2018 we will have achieved:-

- Implementation of Radiology Ordering Via TrakCare;
- Internal referrals via TrakCare;
- Pilot of e-Observation/Ward Monitoring Dashboard;

Our key priorities for 2018/19 include:

- Deployment of E-observations solution and mobile devices;
- Full deployment of Electronic Prescribing;
- Development of Nurse Task Lists;

In addition, developments for documentation, single assessment and medical clerking include:

- Full Discharge Summaries;
- Pathology Ordering;
- DrDoctor (Phase 2) Appointment Requesting/Booking online;
- DrDoctor (Phase 3) Online access to documentation/communications;
- Shared care record engagement – increased analytics of population datasets.

This work will underpin the countywide strategy to improve the sharing of information across heath and care providers to improve the patient experience and ensure safer care.

2.3 Participation in National Clinical Audit and Confidential Enquiries

During 2017/18 there were 54 national clinical audits and 4 national confidential enquiries that covered relevant health services that Yeovil District Hospital provides.

During that period Yeovil District Hospital participated in 97% national clinical audits and 100% national confidential enquiries of those in which it was eligible to participate in.

There was one national clinical audit that the Trust was eligible to participate in but did not: British Obesity and Metabolic Surgery Society – National Bariatric Surgery Registry (NBSR).

The national clinical audits and national confidential enquiries that Yeovil District Hospital participated in and for which data collection was completed during 2017/18 are listed below alongside the number of cases submitted to audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Clinical Audit Title	Cases submitted
National Institute for Cardiovascular Outcomes Research (NICOR) – Acute Myocardial Ischaemia National Audit Programme (MINAP)	Continuous audit of all eligible patients
National Institute for Cardiovascular Outcomes Research (NICOR) – National Heart Failure Audit	Continuous audit of all eligible patients
Royal College of Anaesthetists – National Emergency Laparotomy Audit	Continuous audit of all eligible patients
Royal College of Physicians Inflammatory Bowel Disease (IBD) Audit Programme – Inflammatory Bowel Disease Registry	Continuous audit of all eligible patients
Royal College of Physicians – Sentinel Stroke National Audit Programme (SSNAP)	Continuous audit of all eligible patients
Royal College of Physicians – Falls and Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Audit	Continuous audit of all eligible patients
Royal College of Physicians – National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Continuous audit of all eligible patients
Royal College of Paediatrics and Child Health – National Paediatric Diabetes Audit (NPDA)	Continuous audit of all eligible patients
NHS Digital – National Diabetes Audit (NDA)	Continuous audit of all eligible patients
NHS Digital – National Pregnancy in Diabetes Audit (NPID)	Continuous audit of all eligible patients
National Perinatal Epidemiology Unit (MBRRACE-UK) – Maternal, New Born and Infant Clinical Outcome Review Programme	Continuous audit of all eligible patients
Royal College of Paediatrics and Child Health – National Neonatal Audit Programme (NNAP). Neonatal Intensive and Special Care.	Continuous audit of all eligible patients
Intensive Care National Audit and Research Centre (ICNARC) – Case Mix Programme (CMP)	Continuous audit of all eligible patients
Intensive Care National Audit and Research Centre (ICNARC) – National Cardiac Arrest Audit (NCAA)	Continuous audit of all eligible patients
Trauma Audit and Research Network (TARN) – Major Trauma Audit	Continuous audit of all eligible patients
Healthcare Quality Improvement Partnership (HQIP) – National Joint Registry (NJR)	Continuous audit of all eligible patients
UK National Haemovigilance Scheme - Serious Hazards of Transfusion (SHOT)	Continuous audit of all eligible patients
Royal College of Surgeons – National Bowel Cancer Audit (NBOCAP)	Continuous audit of all eligible patients
Royal College of Physicians – National Lung Cancer Audit (NLCA)	Continuous audit of all eligible patients
Royal College of Surgeons – National Audit of Oesophago-gastric Cancer (NAOGC)	Continuous audit of all eligible patients
Royal College of Surgeons – National Audit of Prostate Cancer	Continuous audit of all eligible patients
Learning Disability Mortality Review Programme (LeDeR Programme)	Continuous audit of all eligible patients
Cystic Fibrosis Trust – UK Cystic Fibrosis Registry	Continuous audit of all eligible patients

Royal College of Obstetricians and Gynaecologists - National Maternity and Perinatal Audit	Continuous audit of all eligible patients
Health and Social Care Information Centre – Patient Reported Outcome Measures (PROMS) for elective hip replacements	Continuous audit of all eligible patients for part of year (new system for data collection and submission introduced)
Health and Social Care Information Centre – Patient Reported Outcome Measures (PROMS) for elective knee replacements	Continuous audit of all eligible patients for part of year (new system for data collection and submission introduced)
Royal College of Physicians – Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of Inpatient Falls (NAIF)	100% minimum requirement
NHS Digital – National Adult Diabetes Inpatient Audit (NADIA)	100% minimum requirement
UK Parkinson's – UK Parkinson's Audit	100% minimum requirement
NHS Blood and Transplant National Comparative Audit of Blood Transfusion Programme (NCABT) – Re-audit of Patient Blood Management in Adults Undergoing Scheduled Surgery	100% minimum requirement
NHS Blood and Transplant National Comparative Audit of Blood Transfusion Programme (NCABT) - 2017 Audit of the management of patients at risk of Transfusion Associated Circulatory Overload	100% minimum requirement
Royal College of Surgeons - National Audit of Breast Cancer in Older Patients (NABCOP)	100% minimum requirement
Royal College of Ophthalmologists - National Ophthalmology Audit	100% minimum requirement
Royal College of Psychiatrists – National Audit of Dementia	100% minimum requirement
Royal College of Psychiatrists – Delirium Screening and Assessment Spotlight National Audit	100% minimum requirement
The College of Emergency Medicine – Fractured Neck of Femur Audit	100% minimum requirement
The College of Emergency Medicine – Pain in Children Audit	100% minimum requirement
The College of Emergency Medicine – Procedural Sedation in Adults Audit	100% minimum requirement
NHS England 7 Day Hospital Services - National 7 Day Working Audit	100% minimum requirement
NHS Improvement Getting It Right First Time - Surgical Site Infection Audit	100% minimum requirement
Accuracy of Prostate MRI in Pathologically Proven Prostate Cancer	100% minimum requirement
Healthcare Quality Improvement Partnership (HQIP) – National Audit of Seizures and Epilepsies in Children and Young People. Epilepsy 12	100% minimum requirement

All published audit reports are reviewed by the clinical teams and the publication date is reported to the Clinical Outcomes Committee. The reports of 32 national clinical audits were reviewed by the provider in 2017/18 and Yeovil District Hospital intends to take the following actions to improve the quality of healthcare provided.

Royal College of Ophthalmologists - National Ophthalmology Audit

The aim of this audit is to prospectively collect, collate and analyse a standardised, nationally agreed cataract surgery dataset from all centres providing NHS cataract surgery in England and Wales to update benchmark standards of care and provide a quality improvement tool. Actions include:

- Doctors plan for the operation of the 2nd eye at the time of listing for the 1st eye;
- Participation in the Cat-Prom5 quest (patient outcome feedback survey);
- Careful recording of co-pathologies before surgery and the careful calculation of risk of PCR (Posterior Capsule Rupture) using the Medisoft tool for every cataract patient;
- The setting up of a system on Medisoft that will enable Optometrists in the region to supply feedback of the best corrected Visual Acuity up to 3 months from surgery.

These recommendations will be incorporated into future work plans.

Royal College of Physicians – Falls and Fragility Fractures Audit Programme (FFFAP) - National Audit of Inpatient Falls

The aim of this audit is to improve inpatient falls prevention through audit and quality improvement. In the audit report the following areas were highlighted for improvement: assessment and documentation of delirium, continence, lying and standing BP, medication assessment, vision assessment and mobility aid requirement. Actions to improve these areas have been incorporated into the Falls Group work plan, which include:

- Implement a Doctor's review of Medication. Liaise with Junior Doctor's Falls QI project members;
- Review current Multi-Disciplinary Assessment Record for adequate vision checks upon admission;
- Provide nurses with the skills to measure patients for walking aids when OT/physio staff are not available (e.g. if a patient is admitted during the night);
- Encourage patients to bring their own aids into hospital with them – contact SWAST with regard to making this standard practice;
- Education around completion of 4AT (rapid clinical instrument for delirium detection) on Medical Clerking proforma.

Royal College of Psychiatrists – National Audit of Dementia

The aim of this third round audit is to improve the quality of care received by people with dementia in general hospitals. In the audit report the following areas were highlighted for improvement: assessment, nutrition, discharge, documentation and communication. An action plan is in place to address these highlighted issues including:

- Implement delirium screening tool and include dementia assessments in clerking proforma;
- Plan to re-launch protected mealtimes (May 2018 with new meal service);
- Promote eating away from the bedside, to be included in the #endpjparalysis initiative;
- Audit and assessment of pain in line with redesign of hospital pain service;
- Increase compliance with the 'This is Me' document.

Royal College of Obstetricians and Gynaecologists - National Maternity and Perinatal Audit

The aim of this audit is to improve the quality of care provided by maternity services and to identify priority areas for improving outcomes and productivity. In the audit report the following areas were highlighted for improvement: the accurate measurement of fluid loss (separating amniotic fluid), the timing of administering Syntocinon bolus, the prescribing and administering Misoprostol/Tranexamic Acid and the early call for assistance with normal deliveries.

Agreed interventions to address these issues have already been implemented and a re-audit has resulted in higher than national average figures. Actions include:

- Changes to clinical practice to ensure accurate measurement instead of estimation of fluid loss
- Review current practice of administration of Syntocinon
- Ensure separate measurement of amniotic fluid from blood loss
- Early call for consultant assistance with normal deliveries in the event of major haemorrhage

Royal College of Anaesthetists – National Emergency Laparotomy Audit

The aim of this audit is to examine the structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy. Trust performance is measured against the delivery of key processes of care for patients undergoing emergency laparotomy (24 hours a day, 7 days a week).

In the latest report (Year 3: 1 December 2015 - 30 November 2016) there is one red RAG rated performance result indicating a hospital should take steps to improve care - Post-operative assessment of patients aged 70 years and over by a care of the older person specialist (National mean 19.4% - YDH 3.7%). The main action to improve compliance has been the introduction of CEPOD lists 7 days a week in line with national guidance.

National Confidential Enquiries (NCEPOD)

During 2017/18 the Trust was eligible to enter data into the following 4 NCEPOD studies:

Study Name	Cases Included	Progress	Actions
Young People and Young Adults Mental Health	6	Report reviewed and presented	Action plan in place.
Non-invasive Ventilation Study	3	Report published and being reviewed by clinical team	Awaiting report review
Acute Heart Failure	2	Data collection completed	Awaiting publication of report
Perioperative Diabetes	4	Data collection period	Clinicians completing questionnaires

2.4 NICE Quality Standards

All new guidance issued by the National Institute for Health and Care Excellence is reviewed by the Clinical Governance team before being distributed to clinicians for assessment of Trust compliance.

The following table shows the guidance issued and the Trust's position in respect of compliance with those that are applicable:

Guidance Type	Publication	Applicable	Compliant	Partially Compliant	Non-Compliant	Under Review
Clinical Guidelines	Total No.	113	79	34	0	0
	In last year	0	0	0	0	0
NICE Guidelines	Total No.	69	13	34	0	22
	In last year	21	2	9	0	10
Technology Appraisals	Total No.	317	315	0	0	2
	In last year	64	62	0	0	2
Medical Technology	Total No.	17	7	1	0	9
	In last year	4	0	0	0	4
Diagnostic Guidelines	Total No.	12	4	1	1	6
	In last year	2	0	0	0	2
Interventional Procedures	Total No.	28	26	0	0	2
	In last year	2	2	0	0	0
Public Health Guidance	Total No.	28	23	5	0	0
	In last year	0	0	0	0	0

NICE (National Institute for Health and Care Excellence) Quality Standards are designed to drive quality improvement and are derived from NICE Guidance and other evidence sources accredited by NICE.

164 NICE Quality Standards have been issued in total and 16 have been issued in the last year. Of the 164 Quality Standards 132 are applicable to the Trust.

The following table shows the standards issued and the Trust's position in respect of compliance with those that are applicable:

Guidance Type	Publication	Applicable	Compliant	Partially Compliant	Non - Compliant	Under Review
Quality Standards	Total No.	134	59	67	0	8
	In last year	14	0	9	0	5

Partially Compliant Quality Standards include:

NICE Quality Standard 1 Dementia

The Trust participated in the Royal College of Psychiatrists - National Audit of Dementia 2017 (Round 3). The standards for this audit were derived from national and professional guidance including NICE Quality Standards. Results of the audit showed compliance is partial and the following areas were highlighted for improvement: governance, nutrition, discharge and assessment. An action plan is in place.

NICE Quality Standard 86 Falls in older people - assessment after a fall and preventing further falls

The Trust participated in the Royal College of Physicians – Falls and Fragility Fractures Audit Programme (FFFAP) - National Audit of Inpatient Falls 2017 that was based on NICE guidance

and advice from NHS Improvement (NHSI). Results of the audit showed compliance is partial and the following areas were highlighted for improvement: assessment and documentation of delirium, continence, lying and standing BP, medication assessment, vision assessment and mobility aid requirement. Actions to improve these areas have been incorporated into the Falls Group work plan.

NICE Quality Standard 22 Antenatal Care

A local audit was carried out in 2017/18 to establish the Trust's compliance with this quality standard. Results of the audit showed compliance is partial - Statement 1 actions are required to ensure all pregnant women access antenatal care, ideally by 10 weeks. Statement 4 care path way is to be established with dieticians to ensure all pregnant women with a Body Mass Index 30 kg/m2 or above are referred to an appropriately trained person for advice on healthy eating and physical activity. An action plan is in place.

NICE Quality Standard 125 Diabetes in Children and Young People

This Standard is based on NICE Guideline 18 that was published in March 2016. The Standard was reviewed in March 2018 and compliance is partial - Statement 4. Continuous glucose monitoring if recommended has to be funded by patients. Negotiations are taking place jointly with Musgrove Park Hospital (MPH) to produce funding criteria in line with the NICE Guideline. An action plan is in place.

2.5 Participation in Local Clinical Audits

A total of 117 local clinical audits and surveys were performed during 2017/18. The reports of 54 (46%) completed local clinical audits were reviewed by the provider in 2017/18 and Yeovil District Hospital intends to take the following actions to improve the quality of healthcare provided.

Radiology Intervention - Patient Safety Checklist

The aim of the audit was to review the accurate completion of the Radiology Intervention Patient Safety Checklist.

Key Findings:

- None of the three sections (Patient details. Pre and Post-procedure Checks) of the Radiology Intervention Patient Safety Checklist were completed in full and scanned onto Radiology Information System (RIS).

Recommendations:

- Complete all sections (Patient details. Pre and Post-procedure Checks) of the Radiology Intervention Patient Safety Checklist in full and ensure all are scanned onto RIS;
- Amend the signatory from "Nurse in charge" to "Registered Health Care Professional" to encourage all staff to take responsibility for completing documentation;
- Amend the main signatory to include Consultant Sonographer;
- Amend Post procedure checks so that some questions can be answered with N/A (not applicable).

Re-audit Radiology Intervention - Patient Safety Checklist

Key Findings:

- None of the three sections (Patient details. Pre and Post-procedure Checks) of the Radiology Intervention Patient Safety Checklist were completed in full and scanned onto RIS. All details recorded have increased except 'Name of the nurse in charge (after team discussion)'.

Recommendations:

- Discuss findings at Radiology Clinical Governance meeting, stress importance of completing checklist correctly;
- Discuss findings at staff meeting to ensure all Registered Practitioners/HCA's are aware of responsibilities and need to fill out the checklist correctly and scan onto RIS;
- Target of >90% achievable next audit;
- Ensure all modalities have the newest version of checklist on file;
- Snap Re-audit poorly performing modalities in 1 month time.

Appropriateness of usage of Computerised Tomography Pulmonary Angiogram (CTPA) investigation of suspected pulmonary embolism

The aim of the audit was to assess, when being used as the primary imaging investigation, whether CTPA was being used appropriately and also to look at the diagnostic yield of CTPA scans in terms of pulmonary embolism and alternative diagnoses. Key findings and actions taken:

- Discussing with the referring doctors the results of this audit, especially ED doctors (since most requests are from the ED team);
- Presenting the Audit results in the Hospital's Physicians Clinical Governance meeting if possible and making them aware of the importance of adhering to the referral protocol and clear documentation on the request cards;
- Ensure all patients should have chest radiographs prior to justifying a CTPA request;
- Clear documentation of whether local referral protocol is being adhered to.
- Discussion of which is the best way to achieve this.
- Where receiving referral – ask clinician about the WELLS score (VTE Risk tool) and D-dimer (blood test) if available and document on the requesting card.

Safety and efficacy of Apremilast in treating psoriatic arthritis

The aim of the audit was to assess the safety and efficacy of Apremilast in treating psoriatic arthritis (NICE Technology Appraisal Guidance 433).

Key findings and actions taken:

- Identify patients with psychiatric co morbidity before starting Apremilast;
- Inquire about their physical and psychological wellbeing while being on Apremilast during clinical consultation;
- Ensure drug compliance by reducing delay in drug delivery;
- Audit presented at Rheumatology Multidisciplinary team meeting.

The safety of Xen implant for managing advanced glaucoma

The aim of the audit was to ensure clinical safety and efficacy of a new treatment used in the department for advanced glaucoma. (NICE Interventional Procedures Guidance 575).

Key findings and actions taken:

- The Xen audit showed that the procedure was safe and reliable with good outcomes compared to comparative data. No actions required. Abstract submitted and accepted by the College of Ophthalmologists at their annual conference.

2.6 Research and Development

The Trust has a commitment to using research as a driver for improving the local quality of care and patient experience and also contributing to the evidence base both nationally and internationally.

The number of patients receiving relevant health services provided or sub-contracted by Yeovil District Hospital in 2017/18 that were recruited in that period to participate in research approved by a research ethics committee was 824.

There are presently 79 studies open and recruiting, inclusive of randomised clinical trials, observational studies, and 2 sponsored and led by the Trust. We have used the nationally recommended systems and protocols to manage these studies and to ensure results are passed into practice in a timely manner and that our clinical staff stay aware of the latest possible treatment opportunities and give patients the best possible outcomes. We take part in the South West Peninsular Clinical Research Network Patient Experience questionnaire to ensure our service is of a high quality and to action any feedback. The Trust has also actively participated in the National Institute of Health Research (NIHR) national campaigns. The research team have actively organised and attended various events across the Trust and local community to encourage and provide opportunities for involvement in research.

A number of research papers have been published to add to the evidence base for healthcare in the future. Recently results from the CSAW trial that the Trust participated in were published in The Lancet a high impact journal. Other studies that published were the VIP1 study, Scot trial and Gap2 and the REVEAL trial.

By running clinical research studies the Trust are bringing in new techniques, treatment options and opportunities for patients within the hospital. There are several examples of this such as the OTTER 2 trial which is run by the hand physiotherapists and supported by the research department. This is their first involvement in clinical research and they have surpassed their recruitment target.

Our involvement in the PQUIP (Perioperative Quality Improvement Programme) study crosses several clinical disciplines and regularly provides quality reports from patients undergoing major surgery. This information is shared with the clinical and management teams to ensure high quality practice throughout the patient journey. The research team has engaged with junior medical staff to assist with data collection to ensure a team approach and provide opportunities for them to participate in research.

We continue to perform well in stroke research and are the top small acute trust to recruit patients to stroke research across the country. The entire stroke team embed research in their day to day practice. We were also awarded the NIHR 2017 CREST award for surgical oncology research for the work of the colorectal Multidisciplinary team (MDT) in ensuring all patients are offered research opportunities. We also have 6 NIHR Speciality and sub speciality leads within the trust for surgery, colorectal cancer, general surgery, urology, ophthalmology and orthopaedic to champion research across the South West Peninsular. Regular webinars and face to face meetings are conducted with colleagues across the South West Clinical Research network to facilitate sharing good practice and the specialty leads attend national meetings.

The Trust continues to submit applications for prestigious National Institute of Health Research (NIHR) awards. The research team encourages and supports all staff who are interested in developing research proposals enabling the Trust to not only host research but also sponsors research with the objective of streamlining and improving care.

Professor Nader Francis was successful in obtaining a RFPB (Research For Patient Benefit) grant of £245 000 this year and this will enable us to open a multicentre study looking at urinary biomarkers in colorectal cancer. The protocol was developed with input from patients in a local support group and a patient sits on the trial management group meetings to ensure patient involvement at every stage of the study. The research department supports 2 surgical research fellows who worked with Professor Francis to submit seven collaborative grant applications. They have had numerous abstracts and given many presentations at national and international meetings. Additionally, in the last year, the team have published multiple articles in international journals.

We have worked with our colleagues in Somerset Partnership and Musgrove Park Hospital to improve access to research for patients across the county. The Somerset Research Collaboration has grown, recruiting 158 patients and opening 5 studies. We have partnered with Bournemouth University to host a PhD post and, working in collaboration with the Nurse Consultant for Older People, this innovative post will be a study exploring the impact on older people's health and wellbeing from compassionate communication during their admission and in-hospital stay**.**

In summary we are currently the 'small acute hospitals best stroke research recruiter' in the country. We have recruited across a broad portfolio of studies in many specialities and are giving patients many opportunities to participate in new treatments and for our staff to be part of a high performing research active organisation. We sponsor innovative multicentre studies and strive to ensure the Trust is represented globally and we are national award winners for our research contributions.

2.7 Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of Yeovil District Hospital income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Yeovil District Hospital 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.

The CQUIN framework is used by commissioners to agree core quality assurance goals as part of a quality improvement based service contract.

Further details of the agreed goals for 2017/18 and for the following 12 month period is available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

As directed by NHS England a 2 year contract and CQUIN schedule was agreed at the beginning of 2017. This saw 1.5% of the 2.5% available allocated to national CQUIN schemes, and the remaining 1% made available to support engagement with Sustainable Transformation Programmes (STP) as well as being linked to the achievement of a providers control total.

The system rewards excellence by linking a proportion of income to the achievement of specific goals. It is vital that the Trust delivers the required standard to improve the quality of care and patient experience and to ensure the income opportunity is achieved. In 2017/18 the service improvement delivered by the implementation of the CQUIN indicators included:

- A suite of indicators focusing on the Health and Wellbeing of NHS Staff, visitors and patients. Focusing on the physical activity and mental health initiatives as well as a step change in the health of the food offered on the premises;
- A focus on sepsis screening for patients in Emergency Department and Inpatient settings as well as ensuring that antibiotic reviews were undertaken within 3 days in addition to continuing to drive the reduction in antibiotic consumption;
- Collaborating across organisations to improve services for people with mental health needs who present to the Emergency Department by improving the care pathway;
- Supporting the GP Forward View by improving GP access to consultant advice on referrals into secondary care, as well as the transition to e-referrals;

- Supporting the proactive and safe discharge of patients by promoting better patient flow and access to other care settings across health and social care providers by working collaboratively.

2.8 Trust Income against Commissioning for Quality and Innovation Payment Framework

A proportion of Yeovil District Hospital Foundation Trust's income is conditional on achieving quality improvement and innovation goals agreed between the Trust and its commissioners. Any person or body who entered into contract, agreement or arrangement for the provision of relevant healthcare services, through the Commissioning for Quality and Innovation payment framework is eligible to invoice for CQUIN.

The income Yeovil District Hospital Foundation Trust receives is conditional on achieving national and locally agreed goals, this equated to £2,100,000 in 2014/15, £2,060,000 in 2015/16, £2,308,595 for 16/17 and the following for 2017/18:

- Somerset; £1,879,442;
- NHS E – Specialised Services; £71,340;
- Public Health; £20,720;
- Military Health; £7,328;
- Dorset; £351,447;
- Total = £2,330,277.

The CQUIN achievement for 2017/18 is anticipated to be achieved in full. As at Q2, the Trust has achieved 100% compliance with CQUIN indicators.

The CQUIN programme for 2018/19 was set as part of the 2 year contract signed in 2017/18 will continue to focus on supporting the Sustainable Transformation Plan and relevant National CQUINs.

2.9 Review of Our Services

During 2017/18 Yeovil District Hospital NHS Foundation Trust provided 44 NHS services. Yeovil District Hospital NHS Foundation Trust has reviewed all of the data available to it on the quality of care in all of these NHS services. Services include those provided by subsidiary organisations.

The income generated by direct provision of NHS services was approximately 82.4% of total income.

2.10 Registration and Compliance

Yeovil District Hospital is required to register with the Care Quality Commission and its current registration status is Requires Improvement. Yeovil District Hospital has the following conditions on registrations – none.

The Care Quality Commission has not taken enforcement against Yeovil District Hospital during 2017/18.

Yeovil District Hospital has not participated in any special reviews or investigations by the CQC during the reporting period.

Services ratings are described in the following table:

CQC Service Ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

A comprehensive action plan was developed as result of the report and this has further informed our Quality Priorities. This action plan is subject to review and monitoring via the Governance Assurance Committee to ensure progress is evident. A further inspection, using the CQC modified inspection process, is anticipated in 2018.

Areas identified as improved included the following examples:

- Aspects of infection control across the Trust;
- Improving quality assurance for the use of resuscitation equipment across the Emergency department, maternity services and children services ;
- Increasing compliance with staff appraisals;
- Strengthening arrangements for End of Life Care in line with National Standards;
- Increased compliance with Level 3 Children's Safeguarding in targeted staff groups/departments;

All actions have been taken and completed in response to the recommendations from the CQC and work is ongoing to maintain compliance.

2.11 National and Contractual Quality Standards

Domain	Indicator	Source	Latest Date Range	This Years Value	Last Years Value	Best Performance (National)	Worst Performance (National)	National Average	National Target
Organisational Health	Overall patient Experience of Hospital Care	NHS Digital	Aug16-Jan17	76.6	76.5	91.0	71.0	78.0	-
	Responsiveness to patients' needs	NHS Digital	Aug16-Jan17	66.3	70.4	86.2	58.9	68.1	-
	Staff Sickness	Trust	Apr17-Feb18	3.0%	3.1%	-	-	-	-
	Staff Turnover	Trust	Apr17-Mar18	17.8%	21.0%	-	-	-	-
	NHS Staff Survey Response rate	Trust	Apr17-Mar18	58%	64.4%	76.6%	31.3%	44.0%	-
Effective	Palliative Care Coding	NHS Digital	Octl16-Sept17	30%	29%	58.6%	11.2%	31.2%	-
	SHMI	NHS Digital	Octl16-Sept17	96.2	98.0	72.7	1.25	100	100
	PROMS: Hip Replacement - EQ VAS	NHS Digital	Apr16-Mar17	71.9%	71.0%	-	-	67.2%	-
	PROMS: Hip Replacement - EQ 5D Index	NHS Digital	Apr16-Mar17	90.2%	88.0%	-	-	89.1%	-
	PROMS: Hip Replacement - Oxford Hip Score	NHS Digital	Apr16-Mar17	95.4%	97.0%	-	-	96.8%	-
	PROMS: Knee Replacement - EQ VAS	NHS Digital	Apr16-Mar17	48.7%	67.0%	-	-	57.4%	-
	PROMS: Knee Replacement - EQ 5D Index	NHS Digital	Apr16-Mar17	73.2%	87.0%	-	-	81.1%	-

	PROMS: Knee Replacement - Oxford Knee Score	NHS Digital	Apr16-Mar17	100.0%	98.0%	-	-	93.8%	-
	Readmissions in 28days: 0-15yrs	NHS Digital	Apr16-Mar17	0.50%	2.91%	-	-	-	-
	Readmissions in 28days: 16yrs+	NHS Digital	Apr16-Mar17	9.40%	7.41%	-	-	-	-
Caring	MSA Breaches	NHS Digital	Apr17-Mar18	0	2	-	-	-	-
	Complaints rate	Trust	Apr17-Mar18	7.3	12.6	-	-	-	-
	Staff - Friends and Family Test	NHS Digital	2017	32.2	66.1	-	-	-	-
	Maternity - Friends and Family Test	NHS Digital	Apr17-Mar18	96.9%	87.3%	-	-	-	-
	Inpatients and Daycases - Friends and Family Test	NHS Digital	Apr17-Mar18	94.9%	90.6%	-	-	-	-
	Emergency Dept - Friends and Family Test	NHS Digital	Apr17-Mar18	94.4%	90.4%	-	-	-	-
Safe	VTE Risk Assessment	NHS Digital	Apr17-Mar18	92.1%	92.6%	100.0%	63.0%	95.5%	95.0%
	Safety alerts	NHS Digital	Apr17-Mar18	0	0				-
	Never Events	NHS Digital	Apr17-Mar18	1	2	-	-	-	-
	Emergency C -Section Rates	Trust	Apr17-Mar18	17.5%	15.5%	-	-	-	
	Rate of C.difficile infection per 100,000 bed days	NHS Digital	Apr17-Mar18	7.8	14.7	0	82.7	13.2	-

	MRSA bacteraemias	NHS Digital	Apr17-Mar18	0	0	0	12	2.0	-
	Rate per 1000 bed days - Patient safety incidents	Trust	Apr17-Mar18	41.0	36.9	-	-	-	-
	Percentage of Patient Safety Incidents that resulted in severe harm or death.	Trust	Apr17-Mar18	0.019%	0.018%				-
Risk Assessment Framework Indicators	Clostridium (C.) difficile – meeting the C. difficile objective (All)	NHS Digital	Apr17-Mar18	4	9	-	-	-	-
	Certification against compliance with requirements regarding access to health care for people with a learning disability	Trust Board Declaration	Apr17-Mar18	Compliant	Compliant	-	-	-	-
	62 day wait for first treatment from urgent GP referral: all cancers	CWT RETURN	Apr17-Feb18	83.8%	85.9%	-	-	-	85.0%
	62 day wait for first treatment from consultant screening service referral: all cancers	CWT RETURN	Apr17-Feb18	94.4%	84.6%	-	-	-	90.0%
	31 day wait from diagnosis to first treatment: all cancers	CWT RETURN	Apr17-Feb18	97.8%	97.7%	-	-	-	96.0%
	31 day wait for second or subsequent treatment: surgery	CWT RETURN	Apr17-Feb18	95.6%	91.5%	-	-	-	94.0%

	31 day wait for second or subsequent treatment: anti cancer drug	CWT RETURN	Apr17-Feb18	100.0%	98.3%	-	-	-	98.0%
	Two week wait from referrals to date first seen: all cancers	CWT RETURN	Apr17-Feb18	95.2%	93.2%	-	-	-	93.0%
	Two week wait from referrals to date first seen: breast symptoms	CWT RETURN	Apr17-Feb18	95.2%	96.4%	-	-	-	93.0%
	18 week maximum wait from point of referral to treatment (incomplete pathways)	UNIFY RETURN	Apr17-Mar18	93.3%	90.8%	-	-	-	92.0%
	Maximum 6-week wait for diagnostic procedures	WEEKLY SITREP	Apr17-Mar18	99.0%	99.2%	-	-	-	99.0%
	SHMMaximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	WEEKLY SITREP	Apr17-Mar18	96.9%	93.8%	-	-	-	95.0%

Yeovil District Hospital considers that SHMI data is described for the following reasons:

- SHMI has remained within the expected range

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:

- Establishing a Mortality review Group
- Monitoring CRAB and HSMR
- Increasing accuracy of palliative care coding

Yeovil District Hospital considers that PROMS data is described for the following reasons:

- In October 2017 the Trust took the decision to cease reporting hernia repair as it was no longer a mandatory requirement. Varicose Vein surgery is not undertaken.
- Health and Social Care Information Centre (HSCIC) data for the reporting period has not yet been published.

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:

- Increasing the number of patient pathways capturing PROMS
- Introducing digital solutions and consultant level dashboards to monitor clinical and patient reporting outcomes

Yeovil District Hospital considers that 28 day re-admissions data is described for the following reasons:

- 0-15 years of age – within expected range
- 16 or over – within expected range

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:

- Regular audit of emergency readmissions to determine avoidability
- Increased focused and support on community services and social care to improve discharge processes including Home First.

Yeovil District Hospital considers that responsiveness to the personal needs of its patients data is described for the following reasons:

- Need for improvement in shared planning and decision making about treatment options
- Need for improved communication about discharge arrangements

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:

- Introducing revised documentation to improve written records of discussions with patients
- Commencing a Quality Improvement project to improve the safety and experience of discharge from hospital

Yeovil District Hospital considers that staff Friends and Family data is described for the following reasons:

- A reduction in numbers of surveys collated during the reporting period (although above the national average)
- Need to improve communication and engagement with identified staff groups
- Current vacancies and high turnover in identified staff groups creating increased pressure on services

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:

- Establishing a Nurse/Midwife Retention Plan
- Developing a Health and Wellbeing plan
- Setting up Staff Networks to improve engagement and communication

Yeovil District Hospital considers that VTE data is described for the following reasons:

- A change in data capture systems following implementation of TrakCare

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:

- Re-establishing mechanisms for data capture
- Reviewing the planned implementation of EPMA (electronic prescribing) to ensure VTE assessment is captured.
- Triangulation of VTE assessments with Safety Thermometer data

Yeovil District Hospital considers that C.diff data is described for the following reasons:

- Significant focus on prudent antibiotic prescribing and rapid isolation of suspected cases

Yeovil District Hospital has taken the following actions to improve this indicator, and so the quality of its services, by:

- Continued focus on robust infection control practices

Yeovil District Hospital considers that the percentage of patient safety incidents that resulted in severe harm or death is described for the following reasons:

- Increased focus on improving rates of reporting to determine risks without harm, thus allowing for earlier mitigation
- Improved engagement with clinical staff on patient safety risks and risk awareness

Yeovil District Hospital will take the following actions to improve this indicator, and so the quality of its services, by:

- Continued focus on risk management awareness and training
- Audit of feedback and prompts to managers to provide details of actions taken

The target for A&E performance was achieved for the year-end, the auditors sampled 20 records from the reporting period and provided an unqualified position.

The auditor's opinion for Referral To Treatment Time (RTT) is that the indicator percentage reported is accurate but with a number of inaccuracies in recording of clock start times thus giving a qualified opinion.

Yeovil District Hospital considers that the data for Referral To Treatment (RTT) is as described due to a number of errors identified with accuracy of clock start times of the patients sampled,

The Trust intends to take the following actions to improve this position as follows:

- Improve the accuracy of documented clock start and stop times by adopting a standard operating procedure
- Internal monthly audit to monitor compliance

2.12 Data Quality

A clinical coding audit was undertaken by CHKS on behalf of YDH which examined the clinical coding accuracy of 155 spells for activity between June and August 2017. The areas reviewed were known trouble areas with limited case note availability and poor documentation as follows: gynaecology, paediatrics, ambulatory care, maternity and a further general sample. Further audit is scheduled for Q4 2018.

Table 1: Summary findings from the audit

Area	Spells tested	% of spells changing payment	% clinical codes incorrect
Overall	**155**	**14.2**	**14.3**

The error rate resulted in a gross financial error of £10,655. The net impact of this was a £7,983 undercharge to commissioners for the sample audited. The coding accuracy achieved information governance toolkit (IGT) level 3 (good) in one out of four coding indicators, level 2 (adequate) in two areas and level 1 in one area. This is subject to change with the awaited final 17/18 Q4 audit.

Table 2: IGT levels of attainment

	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
IGT level 3 requirement	>=95.0%	>=90.0%	>=95.0%	>=90.0%
IGT level 2 requirement	>=90.0%	>=80.0%	>=90.0%	>=80.0%
Yeovil	**87.6%**	**82.8%**	**93.0%**	**94.7%**

The hospital accuracy levels were at Level 1 overall due to errors in primary diagnoses although is only 2.4% off achieving IGT level 2 overall. Further audit is planned in Feb 2018 to assess improvement in accuracy following training and feedback after the audit findings. Primary procedure coding remains consistent with the 16/17 audit findings (93.6%) whilst

secondary procedure coding has seen a large improvement from the 16/17 audit findings (86.7%).
Audit findings have been fed back to the clinical coders both on an individual basis as well as a group session highlighting all sources of coder error with all required post audit training implemented in a timely manner following audit findings.

The completion of clinical coding remains at 99% coded by day 3 which has been highlighted as a potential cause of the increased error rate in diagnostic coding with a view to potentially extend this turnaround time to increase diagnostic accuracy. This pressure of work has resulted in the department recruiting for a further qualified coder to help maintain coding turnaround timeframes whilst improving accuracy.

Additional actions include issue of standard guidance for recording of information for ambulatory care pathways and guidance on documentation for medical staff to improve recording of primary diagnoses and making the full medical record available to the coding department.

The action plan from the 16/17 audit has proved successful showing a further increase in procedure coding accuracy through continued extended guided study in TandO post qualification and common operation code consultant validation.

Unfortunately the in house trust auditor left early in the 17/18 financial year but further audits are planned for 2018/19 to ensure improvement on the areas highlighted in the 17/18 audit.

Payment by Results (PbR) Audit 2017/18

Yeovil District Hospital was not subject to a Payments by Results clinical coding audit during the reporting period by the Audit Commission however, a PbR clinical coding assurance audit was commissioned leading into Q1 2017/18, undertaken by CHKS, to provide an independent view on whether data for selected areas (trauma and orthopaedics, nervous system, paediatrics and a random sample) accurately reflects patient care, that payment is correct under national rules and to assess the potential impact of HRG4+.

This audit also fulfilled the IG toolkit requirements showing an overall IGT level 2 with three of the four areas achieving IGT level 3. The error rates reported in this audit from a sample of 246 episodes for diagnosis and procedure coding were as follows:

Table 3: Summary findings from the audit

Description of code	Accuracy %
Primary Diagnosis	93.4
Secondary Diagnosis	92.0
Primary Procedure	94.7
Secondary Procedure	92.6
Health Resource Group 4	95.1
Health Resource Group 4+	90.7

Yeovil District Hospital submitted records during 2017/18 to the Secondary Uses Services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included a valid NHS number was:

- 99.6% for admitted patient care;
- 99.9% for outpatient care;

- 99% for Accident and Emergency Care.

The percentage of records in the published data which included a valid General Medical Practice code was:

- 99.9% for admitted patient care;
- 100% for outpatient care;
- 100% for Accident and Emergency Care.

2.13 Information Governance

The Yeovil District Hospital Information Governance Assessment Report overall score for 2017/18 (version 14) was 76% and was graded Green – Satisfactory.

Work is continuing on Version 14.1 2017/18 of the Information Governance Toolkit to ensure the Trust continues to meet a level 2, satisfactory score across all 45 recommendations. From April 2018, the IG Toolkit will be replaced with the Data Secrecy and Protection Toolkit. The Trust will appoint a Data Protection Officer to strengthen arrangements and ensure compliance with the revised regulations.

Whilst the focus of this work is on Information Sharing, Data Quality, Records Management, Asset Management and Corporate Records Management, we are working to align compliance with the requirements laid down by General Data Protection Regulations which are due to come into force on 25 May 2018.

Part Three: Other Information

3.1 Staff Survey 2017

The results of the 2017 Staff Survey show that the Trust is above average in many areas. Our response rate was 58%, a reduction on the previous year's response rate but remains above the national average of 44%.

Headline results show us that:

- 78% of staff feel their manager is supportive;
- 3.83/5 staff are positive about team working ;
- 57% of staff reported that managers ask staff for their opinion;
- 71% of staff felt we take a positive interest in their health and wellbeing;
- 86% report that training has helped staff do their job effectively;
- 86% of staff are encouraged to report errors or near misses, and are treated fairly.

However, there are some things we still need to improve on, such as:

- 27% of staff reported that Trust values are not discussed at appraisal;
- 57% of staff would recommend YDH as a place to work;
- 53% of staff receive feedback on incidents reported.

Our five top ranking scores are: Low percentage of staff attending work when unwell; support from immediate managers; experiences of harassment and bullying from staff; when bullying and harassment occurs staff are willing to report it; and team working is effective.

Our five bottom ranking scores are: staff agreeing their role makes a difference to patients; percentage of staff appraised; number of staff experiencing violence from patients and their relatives; fairness and effectiveness of reporting procedures; and staff recommending the trust as a place to work and receive treatment.

We are determined to continually improve and make Yeovil District Hospital a better place to work, and to support this we have put in place a leadership development programme as part of our vision to support and develop our people. The programme involves managers completing a self-assessment tool to help them create an action plan tailored to their own needs. Managers select from over 40 courses, some of which address harassment and bullying. As well as self-selection, managers who we consider would benefit from this training, will be asked to attend relevant programmes.

The survey results have been shared with staff, and we are involving them in developing improvement plans to make Yeovil District Hospital a fantastic place to work and receive care.

3.2 Patient Safety and Quality Improvement

The Trust demonstrates its ongoing commitment to Patient Safety and continues to enrol delegates on the South West Academic Health Science Network (AHSN) Patient Safety Launch Pad Programme each year. The Patient Safety Launch Pad is a five day programme, spread across 9 months and is designed to support staff in implementing patient safety and quality improvement plans at ward, unit, and hospital or system level.

The Trust uses the LIFE system to effectively monitor and manage Quality Improvement (QI) plans. Life is a purpose built Healthcare QI tool and has everything needed to run a QI project in one place. It is used by hundreds of health and social care organisations across the globe to facilitate quality improvement work and makes it easy for teams to collaborate on QI projects.

The Trust also uses the SCORE survey to measure the safety culture of teams and departments. The anonymous and private survey allows individuals and teams to gain an important perspective on the Trust's current patient safety culture, identifying areas of strength and areas for improvement. The SCORE survey is not a benchmarking exercise but gives teams the chance to influence change for themselves. To date, Therapies, Pharmacy and Maternity have taken part in the survey with positive outcomes.

We all recognise that healthcare carries some risk and while everyone working in the NHS works hard every day to reduce this risk, harm still happens. Whenever possible, we must do all we can to deliver harm free care for every patient, every time, everywhere. We must be open with our patients and colleagues about the potential for things to go wrong and for people to get hurt, and most of all, we must continuously learn from what happens in order to improve.

Our Patient Safety Improvement plan incorporates national recommendations, including safe staffing levels, and local priorities that reflect our patients' needs. We implement and monitor the Safety Improvement Plan through our Harm Free and Patient Safety Groups and by progress against CQUIN targets:

- Medicines Committee;
- Recognition and Rescue Group (Deteriorating Patients, AKI, Sepsis);
- Pressure Ulcer Steering Group;
- Falls Prevention Group;
- Safety Thermometer.

We tackle our proposed projects by using appropriate quality improvement methods, such as Plan Do Study Act (PDSA) cycles, on a project by project basis. What is common to the success of all quality improvement approaches is that they require deep engagement and collaboration. Board oversight is provided by the Governance and Quality Assurance Committee.

Patient Safety

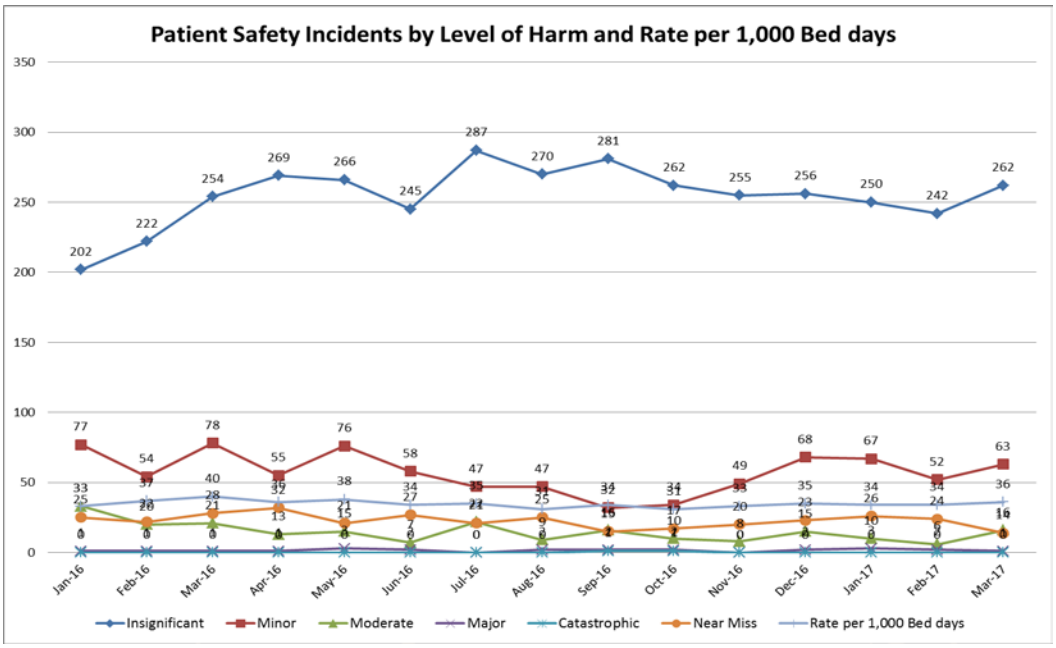
3.3 Patient Safety Incidents

During 2017/18 a total of incidents and accidents reported increased by 415. There were 7,248 reported incidents in 2017/18 compared with 6,828 in the previous year. Of these, 3,790 were patient safety incidents classed as no harm/near miss in line with national guidance. There were 120 patient safety incidents classed as resulting in moderate, severe harm or death, of which 12 were severe and 1 as a result of an unexpected death. The Trust routinely reports all patient safety incidents to the National Reporting and Learning System (NRLS) and adheres to the national policy on incident reporting and investigation. Overall the Trust has seen a rise in incident reporting, demonstrating improvement in safety culture and a reduction in incidents resulting in harm.

The Trust has a positive approach to incident reporting and actively encourages staff to report near misses and patient safety incidents. During the year, the frequency of incident

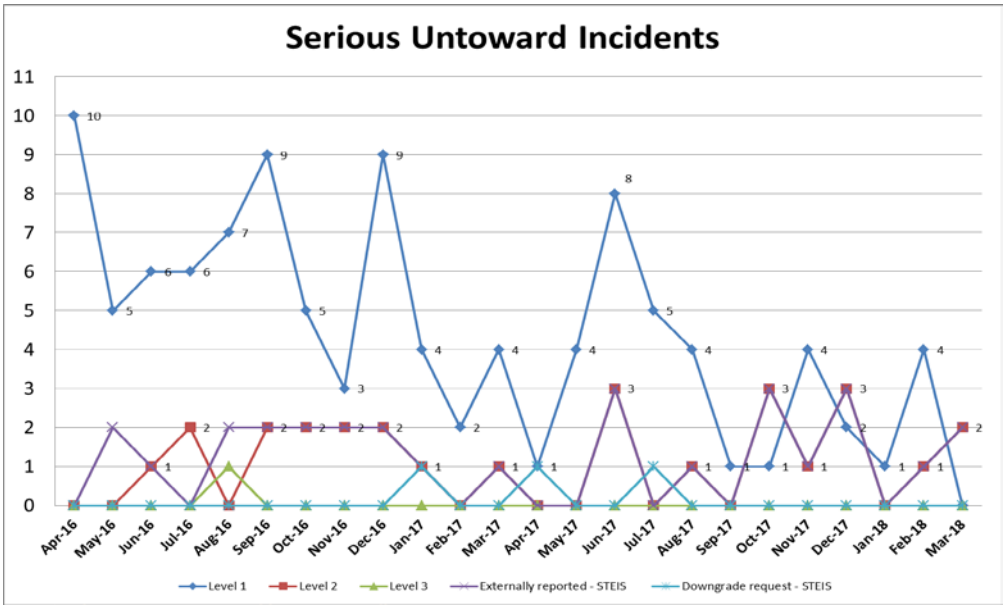
reporting has increased by 6% which has assisted with greater ability to identify trends. All reports are reviewed by a senior manager with comprehensive investigations conducted into the more significant incidents. The aim is to ensure that lessons are learned and then shared widely to reduce the likelihood of a recurrence.

The following chart shows the Patient Safety incident data for 2017/18 and shows the different levels of harm reported.



3.4 Serious Incidents

A total of 52 investigations were commissioned in 2017/18. Of these, 14 required a Comprehensive Root Cause Analysis (Level 2 investigation) and 14 met the definitions of a Serious Incident Requiring Investigation, in accordance with national definitions and guidance, and were reported to Somerset Clinical Commissioning Group. 10 Serious Incidents met the threshold for Duty of Candour which was complied with accordingly.



3.5 Duty of Candour

When a patient safety incident occurs that results in a patient suffering moderate or significant harm the Trust, our staff:

- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that an incident has occurred, and provide support to them in relation to the incident;
- Provide an account of the incident which, to the best of our knowledge, is true of all the facts known about the incident;
- Advise the relevant person what further enquiries we believe are appropriate;
- Offer an apology;
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries;
- Keep a written record of all communication with the relevant person.

The incident reporting system has a section for recording compliance with the Duty of Candour and for including the detail of who has been spoken with (the patient, or where the patient lacks capacity, their next of kin). Patients and/or their family are written to setting out an apology and the process of investigation. Formal investigations include patient involvement and a full copy of the report is shared with them accordingly.

3.6 Learning Lessons

The Trust realises the importance of learning lessons from problems that have occurred. Whenever an incident is reported in the hospital a thorough investigation is carried out and reports are made outlining areas for improvement. This information is shared with all grades of staff at a quarterly Trust-wide meeting. Topics in the last year have included:

- Paracetamol the Safe Drug;
- Recognition and Rescue of the Deteriorating Patient;
- MDT pre-op Assessment of High Risk Patient;
- New Anticoagulation Bridging Policy.

These have led to changes in practice such as:

Fluid/nutrition:

- Launch of a new fluid balance chart;
- Development a new Malnutrition Universal Screening Tool (MUST);
- Development of a feed chart for children, combining a number of different forms.

Recognition and rescue:

- QI project to improve care for people admitted with diabetes.

Discharge – key theme arising from PALs/Complaints:

- Pharmacy projects looking to significantly reduce the time it takes to process medications on discharge;
- Development of Discharge care bundle;
- Exploring ways to speed up the process for writing discharge summaries.

3.7 Healthcare Associated Infections (HCAI)

The Trust has continued to perform well with healthcare associated infections remaining low. A key priority is the delivery of a national ambition to reduce the number of patients with blood stream infection (BSI) from multi-resistant gram negative organisms (MRGNO) such as E.coli. Infections with these organisms are increasingly difficult to treat with limited, effective antibiotics available.

NHS Improvement identified the rise in Gram-negative blood stream infections across the healthcare community. This instigated a national ambition to reduce these infections by 50% by March 2021. As a result, a Somerset wide multidisciplinary working group was formed to address this and agree a robust action plan. Due to the complexity of these infections, it was deemed prudent to focus on the most prevalent source, that being unnecessary catheterisation of patients. As a result of this a local target of a 10% reduction across Somerset within the 17/18 financial year was set.

The target for YDH was 21, this year ended with a YDH total of 23. The improvement work focused on the reduction of unnecessary urinary catheterisation within the Trust and clear documentation of why the required ones are in i.e. revision of the urinary catheter care bundle to incorporate the HOUDINI acronym to facilitate clear identification of the need for the catheterisation. This is supported by a focus on Primary Care prescribing of antibiotics, health promotion around hydration of the population to reduce the incidence of infection and the design of a urinary catheter passport.

This data is reported locally via the patient safety steering group and CCG, we are also required to report this nationally via HCAI DCS Mandatory Surveillance run by Public Health England

The Trust has finished this financial year with a further reduction in identified Health Care Associated Infections. The process involves a Post Infection Review (PIR) to identify learning and any focused improvement work required. This is reported under the heading of ‘lapse in care’ Following review of the cases, no lapses in care were identified to date.

This data is reported locally to the Patient Safety Steering Group and Somerset CCG. We are also required to report this nationally via HCAI DCS Mandatory Surveillance run by Public Health England

The following table provides the number of HCAIs reported in year:

Yeovil Hospital Healthcare

2017-18 INFECTION CONTROL DASHBOARD

Area	Quality Area	Quality Objective	Threshold	2017-18												
				Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Blood Stream Infection	MRSA BSI	Number of provider-acquired infections		0	0	0	0	0	0	0	0	0	0	0	0	0
	MRSA BSI Lapses in Care			0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA BSI			0	0	1	0	0	0	0	0	1	0	1	0	3
	MSSA BSI Lapses in Care			0	0	0	0	0	0	0	0	0	0	0	0	0
	E Coli BSI			0	3	4	1	2	3	0	1	3	1	1	4	23
	E Coli BSI Lapses in Care			0	0	0	0	0	0	0	0	0	0	0	0	0
	Pseudomonas BSI			0	0	0	0	0	0	0	0	0	0	0	0	0
	Pseudomonas BSI Lapses in Care			0	0	0	0	0	0	0	0	0	0	0	0	0
	Klebsiella BSI			0	0	0	1	1	2	1	1	1	0	0	1	8
	Klebsiella BSI Lapses in care			0	0	0	0	0	0	0	0	0	0	0	0	0
Bacterium	Clostridium Difficile Infections			0	1	0	1	3	0	0	0	0	0	0	1	6
	Clostridium Difficile Infections Lapses in Care			0	0	0	0	0	0	0	0	0	0	0	0	0
	Hand Hygiene - Trustwide average of scores submitted	Annual Target 90%		91%	91%	90%	92%	93%	93%	90%	93%	94%	92%	91%	93%	92%

3.8 Preventing Venous Thrombo-embolism (VTE)

We have continued to work on improvements to reduce harm to patients. The national emphasis on preventing venous thrombo-emboli has continued. A thrombosis can be a blood clot in the deep vein of the leg - Deep Vein Thrombosis or DVT and the more serious blood clots in the lung - Pulmonary Embolism or PE. These can form through slowing of blood flow and we know that patients having surgery and those whose mobility is reduced are at particular risk.

To aid with preventing this potential complication we can take several actions. We can give medication to thin the blood, use stockings or mechanical pumps to improve blood flow and encourage our patients to be as mobile as possible.

Every patient should be assessed within 24 hours of admission regarding their individual risk of a thrombosis and the appropriate measures put in place. There are exclusions such as those patients undergoing some types of day case procedures and most patients attending the Emergency Department. We have identified a greater potential risk for patients attending the Emergency Department with Lower limb injuries requiring a plaster that limits their mobility and developed an additional risk assessment and management process for this group of patients.

Compliance with VTE Risk assessment is a key patient safety measure and a nationally reported key quality indicator with a National Target of 95%. The Trust has achieved an overall year end position of 92.1%. The reduction in performance is attributed to a change in electronic data capture with the implementation of Trakcare. Work is being undertaken to ensure robust systems of electronic data capture to improve performance.

We audit compliance with the prophylaxis and management of these patients and if a pulmonary embolism or deep vein thrombosis develops during their admission, or within 90 days of their discharge an investigation is undertaken to identify why this happened. We use the learning from our investigations to improve the care for future patients and are currently looking at the policy including review of existing exclusion criteria.

Compliance with prophylaxis is monitored at Safety Thermometer with compliance reported at 100%.

3.9 Maternity Safety

Our emergency caesarean section rate was 18.2% compared to the year-end target of 15%. This is an increase in comparison to the previous year of 15.5% and work is underway to audit reasons and identify actions for improvement.

Maternity safety and performance is reviewed using the regional dashboard and reported to the Patient Safety Steering Group, Trust Board and CCG Maternity Forum. The Better Births programme will continue to be a key area of focus for the team in 2018/19 with the Trust participating in wave 3 of the Maternity Safety Collaborative in 2019. In advance of this date, the team have already participated in the SCORE culture survey to identify and deliver improvements in safety culture and working practices.

3.10 Clinical Effectiveness

We have a number of processes for understanding effectiveness and monitoring to ensure the care we provide follows national best practice. We have reviewed our work in this area and set revised priorities for delivering improvements.

The Trust`s Clinical Outcomes Committee oversees the compliance and delivery of best practice with a focus of effective outcomes for patients. The committee reviews new guidance from the National Institute of Clinical Excellence and assists clinical teams to assess their compliance with the guidance, identify any gaps and work towards improved practice.

National and Local Audits undertaken within the Trust are reported to the Clinical Outcomes Committee which has developed a specialty based approach. Outcomes from the audits and the resultant action plans are reviewed and new policies, protocols and guidance relating to clinical standards agreed.

3.11 Royal College of Psychiatrists – National Audit of Dementia

The aim of this third round audit is to improve the quality of care received by people with dementia in general hospitals. In the audit report the following areas were highlighted for improvement: assessment, nutrition, discharge, documentation and communication. As a result of the audit, and an increase in patients being admitted to hospital with impaired cognition or a diagnosis of dementia, the following actions have been taken:

- Redesign of the acute admission clerking proforma to include a delirium screen and a frailty scoring system;
- Development of a Dementia strategy and workplan to ensure ongoing improvement and monitoring by the Dementia Steering Group;
- Additional improvements to the built wards and departments to deliver a more ‘dementia friendly’ environment;
- Targeted training on Mental Capacity Assessment (MCA) and Deprivation of Liberty Safeguards (DOLS).

In addition, the Trust has supported the development and provision of a Psychiatric Liaison Team who are based in the hospital and provide an immediate service for the assessment, intervention and management of patients in crisis. The team is employed by Somerset Partnership Trust but work collaboratively with the hospital to deliver clinical intervention, education and training and policy development to improve the care and treatment of patients with mental health needs. This is an important development and a key focus for delivery, in line with the Quality Priorities across the county for 2018/19.

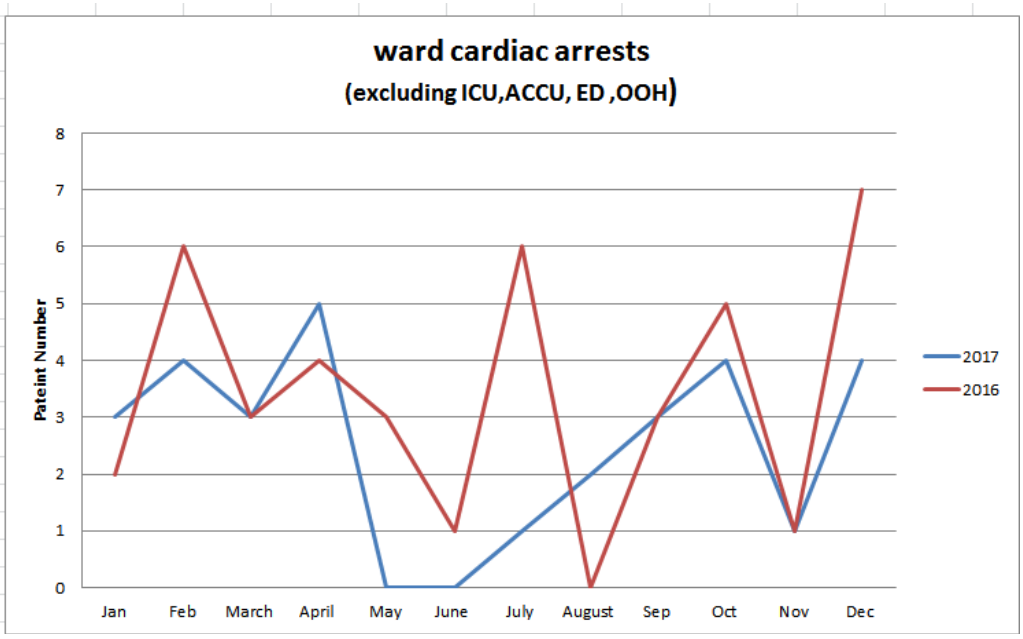
3.12 Recognition and Rescue of the Deteriorating Patient

A Simulation Fellow post was introduced at Yeovil District Hospital in February 2016/17 with the aim of establishing a multi-disciplinary simulation teaching programme to reduce incidents of failure to detect, communicate or respond to deterioration. The program has achieved the following:

- Introduction of ward based simulations focused on sepsis and AKI;
- Deteriorating patient simulation now embedded into junior doctor teaching on a monthly basis;
- Commenced real time trauma simulations in Emergency Department ;
- Introduction of maternal real time simulations;
- The development of a Simulation Faculty;
- Multi-professional simulation days commenced February 2018. Candidates include medical students, nurses and all grades of doctors. The focus remains on the deteriorating patient and human factors;
- The introduction of a trauma simulation course at YDH in January 2018 in partnership with Southmead Hospital Trauma team;
- Targeted simulation teaching for example, training of junior nurses on ACCU who had little experience of arrhythmia identification and management. Short simulations were used to enhance the teaching and ultimately improve staff development and patient safety.

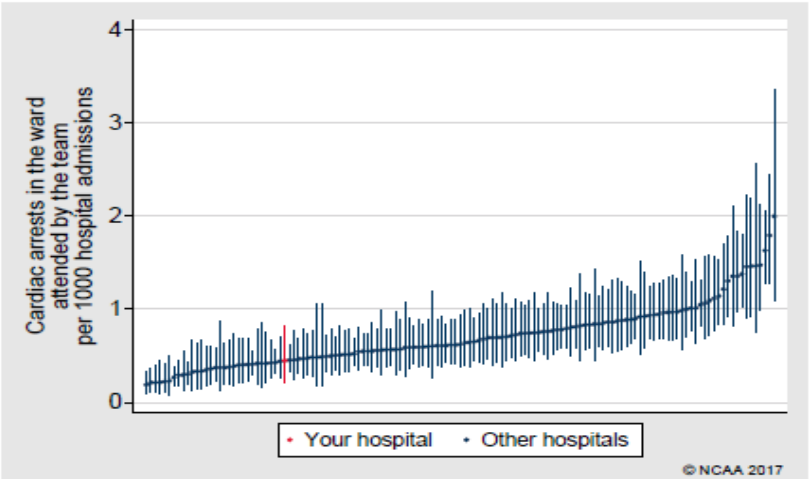
One of the objectives of the Simulation programme was to achieve a reduction in ward-based cardiac arrests. Ward cardiac arrests are seen as a measure of recognition and escalation processes. Following introduction of the programme a 22.5% reduction in ward-based cardiac arrests was achieved with 30 ward based cardiac arrests reported in 2017/18 compared with 41 ward based cardiac arrests the previous year, despite greater patient numbers and acuity.

National Cardiac Arrest Audit 2017



Rate of cardiac arrests - ward

The following graph presents the reported number of in-hospital cardiac arrests attended by the team where the location of arrest was ward per 1,000 hospital admissions for adult, acute hospitals in NCAA.



Work will continue to ensure the Trust remains in the lower quartile of national performance, demonstrating ongoing commitment to early recognition and rescue of patients whose condition is deteriorating. As part of this commitment, we will be working as part of a regional network to implement NEWS2, an updated national early warning score, and introduce STREAMS, a digital observation system that will alert staff to deterioration in vital signs.

3.13 National Inpatient Diabetes Audit

The results of the National Inpatient Diabetes Audit demonstrated that improvement has been achieved in a number of areas including the number of whole time equivalent nurse

specialists available per bed day, number of diabetes foot patients seen by multi-disciplinary team member (100% compared to 80% in 2015) and improvements in patient experience. Improvements are still required in dietetic support hours per patient, completion of end of bed foot assessments

As a consequence, the Trust is participating in a national collaborative to improve the care of patients in hospital who are known to be diabetic. A multi-disciplinary team have undergone training in Quality Improvement to deliver the following improvements over the coming year:

- Increase opportunities for admission avoidance
- Reduce number of prescribing errors and those associated with administration of insulin
- Increase number of end of bed foot assessments and daily check.
- Reduce time of referral to time seen by a Diabetes Nurse Specialist
- Reduce length of stay

The project runs for 12 months and will report on progress to the Clinical Outcomes Committee on a regular basis.

Patient Experience

3.14 National Inpatients Survey 2017

The findings from the 2017 Inpatient Survey were received from the Picker Institute in January 2018. A further public report was received from the CQC in February 2018 included benchmarks against all NHS Trusts.

This annual survey asks the views of adults who had stayed at least one night as an inpatient during the month of July 2017. Patients are asked what they thought about different aspects of the care and treatment they received. The purpose of the survey is to understand what patients think of healthcare services provided by the Trust, and the questionnaire reflects the priorities and concerns of patients based upon what is most important from the perspective of the patient.

A total of 1,250 patients were sent the questionnaire. 1,198 were eligible for the survey, of which 570 returned a completed questionnaire, giving a response rate of 47.6%.

The 2017 survey has highlighted the many positive aspects of the patient experience, including:

- Admission: privacy on examination in ED saw a 6% improvement;
- Admission: in a timely fashion saw a 16% improvement;
- Admission: wait to get into a bed on a ward saw a 7% improvement;
- Nurses: confidence and trust in the nurses saw a 5% improvement;
- Nurses: there were enough nurses on duty at all times saw a 7% improvement;
- Care: involved in decision making saw a 7% improvement;
- Care: emotional support given by staff saw a 9% improvement;
- Discharge: Information for families on discharge saw a 10% improvement;
- Overall: being asked to give views on care saw a 5% improvement;
- Overall received information explaining how to complain saw a 10% improvement;
- Overall: score of greater than 7/10 saw a 5% improvement.

Compared with the results from the 2016 survey, the Trust has significantly improved on planned admissions that should have been admitted sooner by 16%.

When reviewing the Trust's results against the Picker Average (results compared with the 81 other trusts that commissioned Picker to run the survey), the Trust scored better than average for the following questions:

- Hospital: food was fair or poor;
- Hospital: not offered a choice of food;
- Overall: not always well looked after by non-clinical hospital staff.

The Trust has worsened significantly in several areas' relating to patient experience:

- Nurses: did not always know which nurse was in charge of care;
- Discharge: not given notice about when discharge would be;
- Discharge: was delayed;
- Discharge: not given any written/printed information about what they should or should not do after leaving hospital;
- Discharge: not told who to contact if worried;
- Hospital: bothered by noise at night from other patients.

The Trust is aware of the improvement needed from the results of the survey and will be working closely with the patient experience team, nursing, doctors and business managers to ensure improvements are made in these key areas.

3.15 Patient Feedback, Complaints and PALS

During Quarter 1 2017/18 the Patient Experience Team underwent a period of significant transition with the departure of the Patient Experience Manager and two members of staff. However despite these changes the team of staff continued to provide a high quality service to patients and visitors.

A review of the team and processes has been led by the Head of Governance and Assurance. During this time a new Complaints and Concerns Policy was written and ratified. The team's plan to launch the online web based Safeguard (Customer Services) module was implemented and went live on 1st September 2017. To ensure that the system is fully utilised further development and training will continue to take place over the next year.

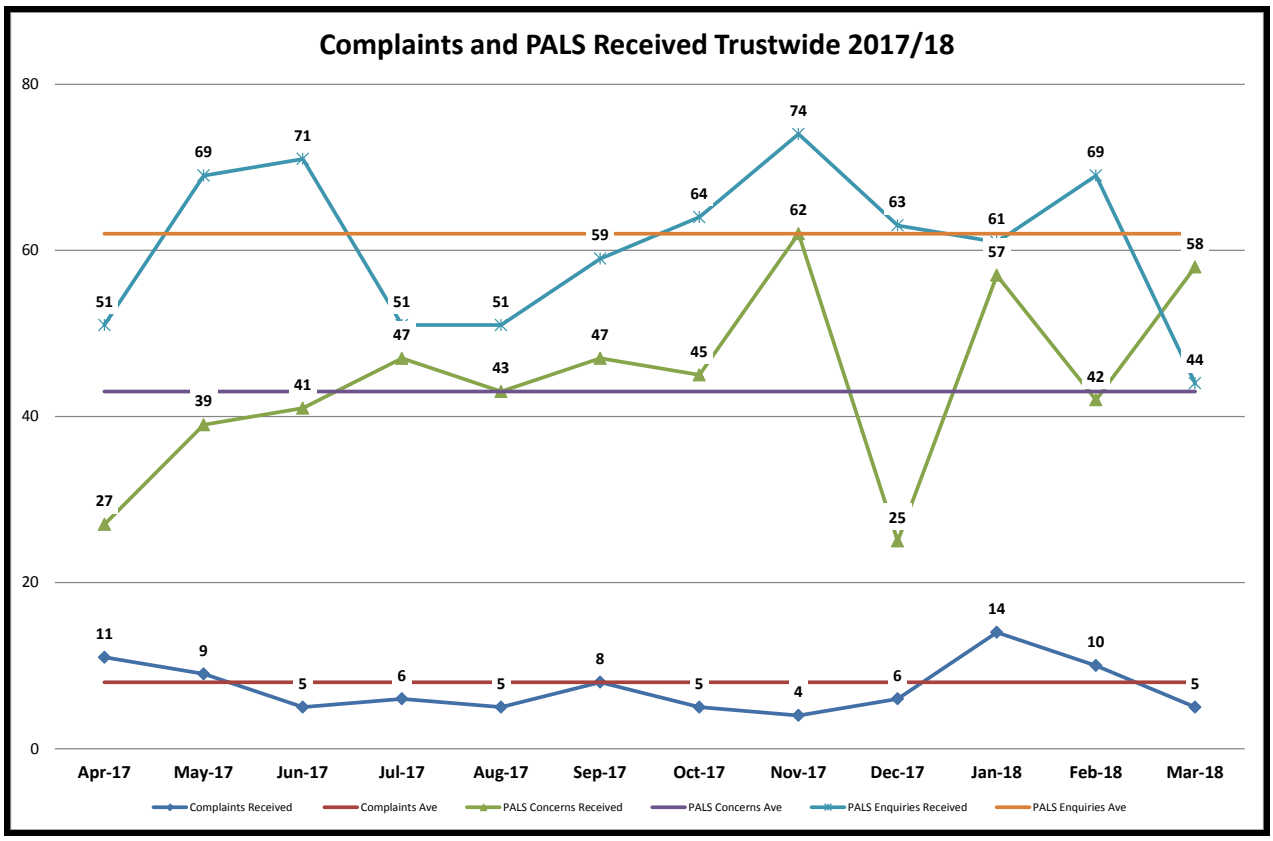
During the year both the Complaints and PALS teams have further developed their processes to ensure a more robust management of formal complaints, PALS enquiries and concerns. Where appropriate, formal complaints responses now include an action plan to address issues identified during our investigations, the actions are implemented by senior members of staff and taken to the Trustwide Learning Forum to be shared throughout the organisation. This will also be implemented for PALS concerns where appropriate during the next 12 months.
At the end of Quarter 4, the team experienced further change with the departure of the current Patient Experience Manager; also the Trust's Engagement Lead has been relocated to the Clinical Governance Team. The Patient Experience Team now provides the following services:

- PALS;
- Complaints;
- Bereavement;

- Friends and Family via "IwantGreatCare" (shared with Clinical Governance).

Following the relaunch of the Patient Experience and Engagement Steering Group, this meeting continues to meet bi-monthly and regular feedback from this meeting will form part of this report in future.

Complaints and enquiries to the Patient Advice and Liaison Service are outlined below:

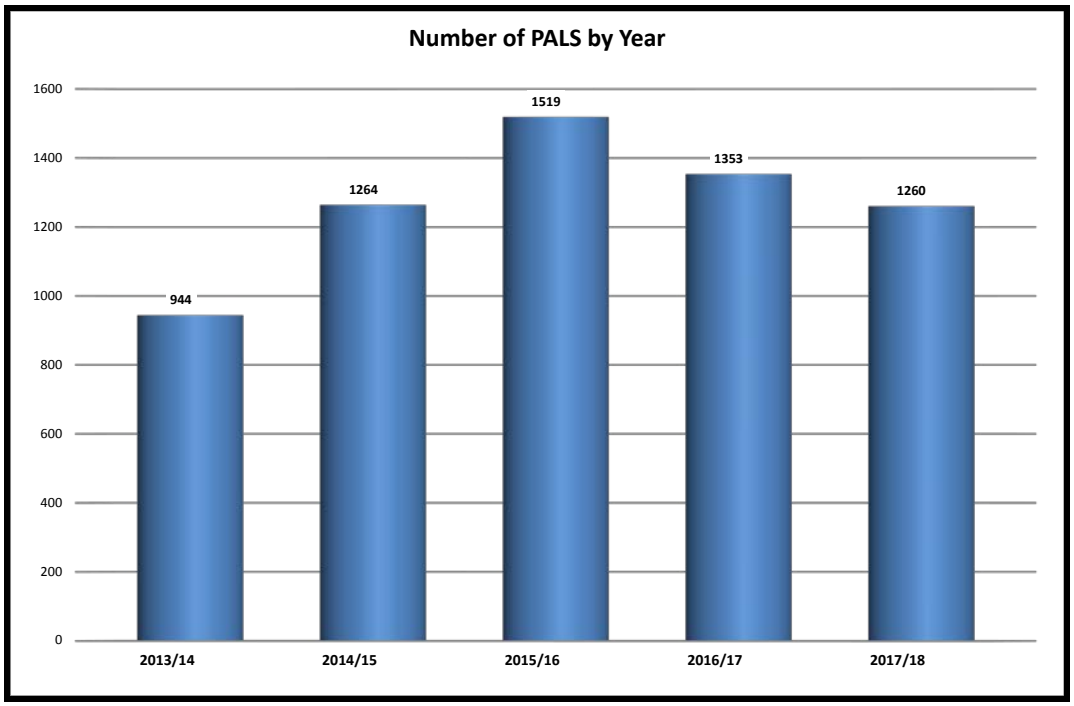


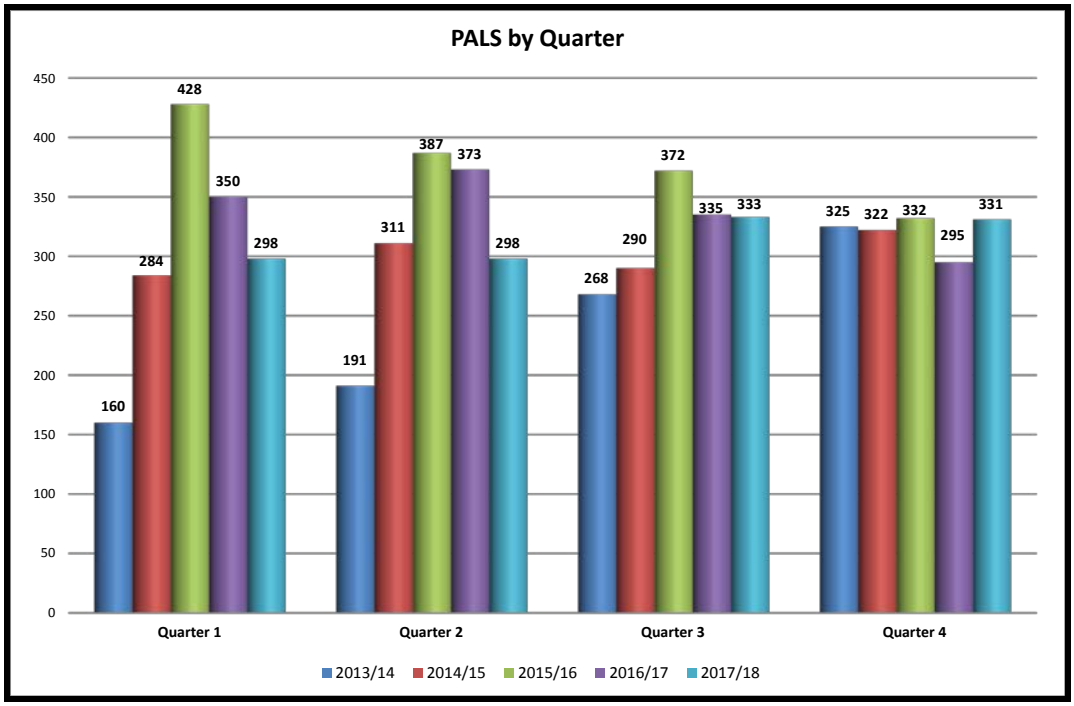
3.16 Patient Advice and Liaison Service

The PALS service took 298 PALS concerns during the first quarter and 298 during quarter 2, 333 during quarter 3, and 331 during quarter 4.

Whilst previously, conciliation meetings were largely conducted as a result of a formal complaint process, a significant number of conciliation meetings now occur as a result of PALS enquiries and bereavement concerns raised when families are collecting a death certificate from the bereavement service. It is clearly evident that when relatives or patients have concerns about care of a patient who is currently in the hospital it is by far more effective to meet with them at the time.

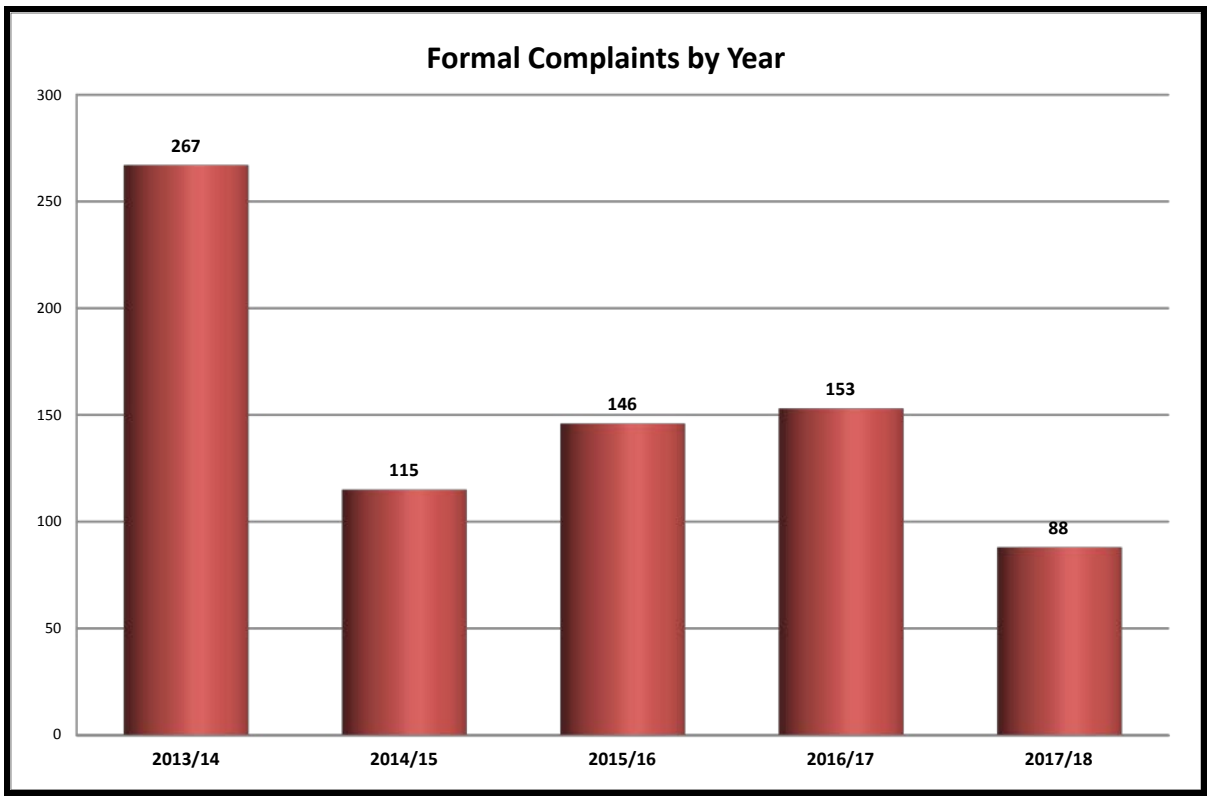
All PALS contacts are now graded as either an enquiry (easily and quickly resolved) or a concern (which needs an investigation) with a steady increase during the last quarter in the number of enquiries and concerns raised via PALS and shown in the graph below. As part of developing smarter working practices, we now provide verbal or email responses to concerns unless specifically requested to be more formally in a letter.


Number of PALS by Year
1600
1400
1200
1000
800
600
400
200
0
944
1264
1519
1353
1260
2013/14
2014/15
2015/16
2016/17
2017/18


PALS by Quarter
450
400
350
300
250
200
150
100
50
0
160
284
428
350
298
191
311
387
373
298
268
290
372
335
333
325
322
332
295
331
Quarter 1
Quarter 2
Quarter 3
Quarter 4
2013/14
2014/15
2015/16
2016/17
2017/18

3.17 Formal complaints

There were 25 formal complaints received during Quarter 1, 19 during Quarter 2, 15 during Quarter 3, and 29 during Quarter 4



Whilst efforts are made to meet agreed deadlines for response, a number of complainants have received holding letters, providing an explanation as to why the complaint response may have been delayed and reasons for these delays. It remains evident that if an explanation is given to a complainant as to a delay then the majority of complainants are content with this process. All complainants continue to be offered a meeting, either at the outset of the complaints process or after a response have been received.

We continue to have an average of ten conciliation meetings each month.

The Head of Clinical Governance and Assurance and the Medical Director play a key role in these meetings which has made them both very effective and enlightening. Clinical input is enormously beneficial and valued by complainants attending such meetings.

3.18 Changes resulting from feedback

- **Change in patient's observations, no request for doctor to review patient prior to discharge** - Testing of 'Discharge Care Bundle' to include a full set of observations taken immediately prior to patient leaving ward and any concerns identified to be escalated and a doctor called to review patient;
- **Distress and discomfort caused to end of life patient and family in carrying out possible non-essential nursing tasks, e.g. bed making** - Ward Sister to share complaint with nursing team and reiterate the need to be mindful of patients' current status and essential needs;

- **Documentation of fluid intake and checking access to fluids, as complainant raised concerns about patient receiving adequate fluids** – Ward Sister to stress importance of completion of fluid balance charts and 'intentional rounding' documentation;
- **Complainant did not understand plan to withdraw treatment following a telephone call with doctor regarding relative being 'end of life'** – discuss complaint at End of Life Steering Group re clarity of conversations;
- **Improve communication with families regarding TEPDNAR and mental capacity** - To be discussed at the Resuscitation and Recognition Steering Group and at ICU Governance Meeting. Review and update training requirements for staff around end of life communication;
- **Family were not contacted when patient was moved to ICU overnight, as patient did not want them to be disturbed, however, family distressed at not knowing** - Review medical and nursing documentation (all wards) to ensure families' wishes are documented regarding any deterioration, in particular if patient is moved to ICU from a ward to ensure appropriate communication with families;
- **Family reported finding medication in patient's dressing gown pocket** - To ensure patients are taking medications at time of administration, letter sent to all ward staff reminding them of their NMC responsibilities when administering drugs. Matron and Ward Sister to monitor drug administration on a daily basis;
- **Failure to book repeat ERCP and stent removal for patient within expected timeframe** – To discuss complaint at speciality governance meeting and ensure written request from Consultant to administrator to book procedure is always supported by email confirmation;
- **Relatives unaware of who to speak to on the ward for an update on patient's condition or how to raise concerns** - To review ward information leaflet/communication and signage on ward to ensure relatives are aware of who to contact for updates and to escalate concerns.

3.19 Patient Feedback Indicators / Patient Surveys

The decision was made that at the end of 2016/17 finance year The Patient Voice Group would no longer facilitate the Trust's Your Care Survey and that they would undertake observational audits that were linked to the Trust's current priorities.

The Patient Voice Group undertook a survey between August 2017 and March 2018 which looked at the patient's experience of their discharge from hospital. The group members would survey patients whilst they were still on the ward to understand their expectation of their discharge and they would then telephone the patient once they had returned home, to ask another set of questions to determine how they felt following their discharge.

The results of the survey were very positive; with 76% of patients being discharged at the time they were told that they would go home, or earlier. 96% of patients stated that they felt well enough to go home and 93% saying they were able to manage once there. Of those patients who were expecting a package of care to be in place following their discharge, only 19% said that this had not been arranged.

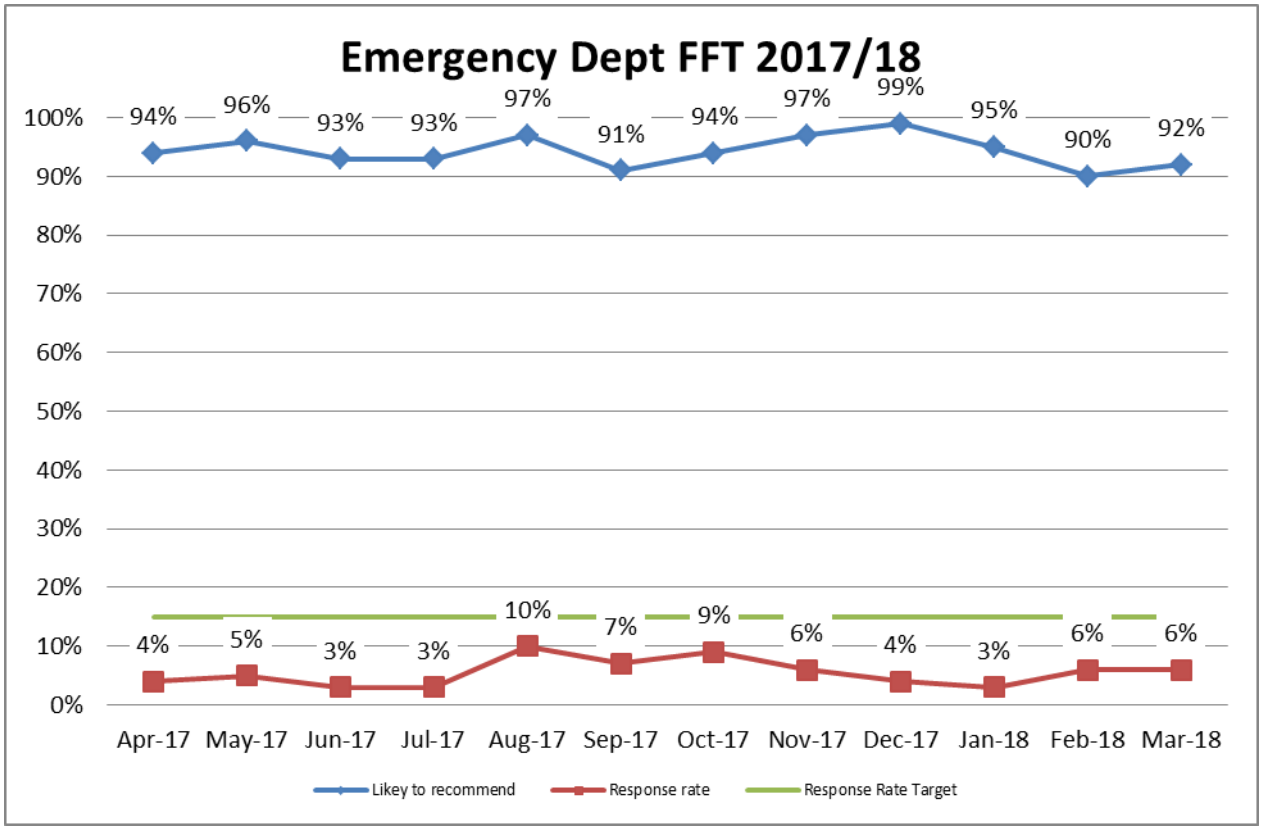
The recommendations arising from the survey were to undertake a review of the questions to ensure that comparative data from both stages of the survey can be collected and that the survey should continue in the future.

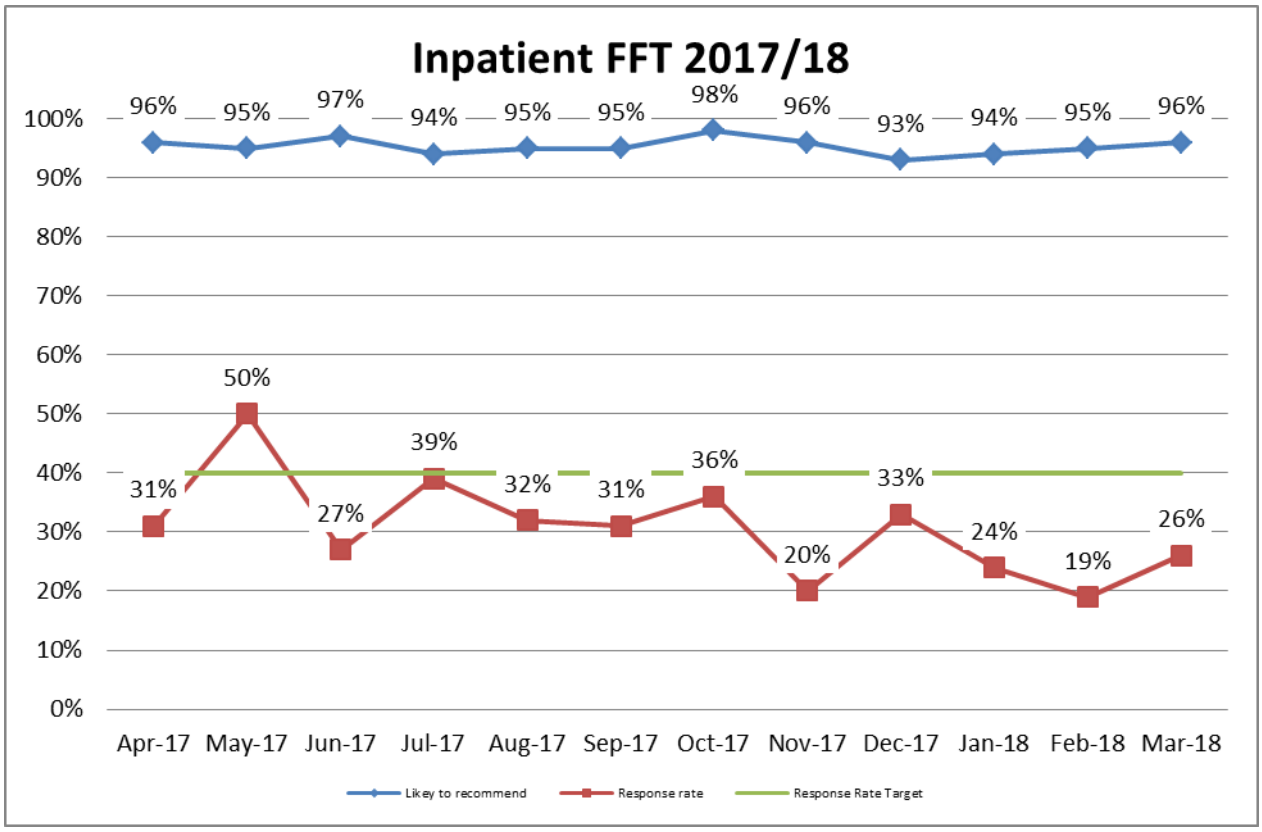
3.20 Friends and Family Test

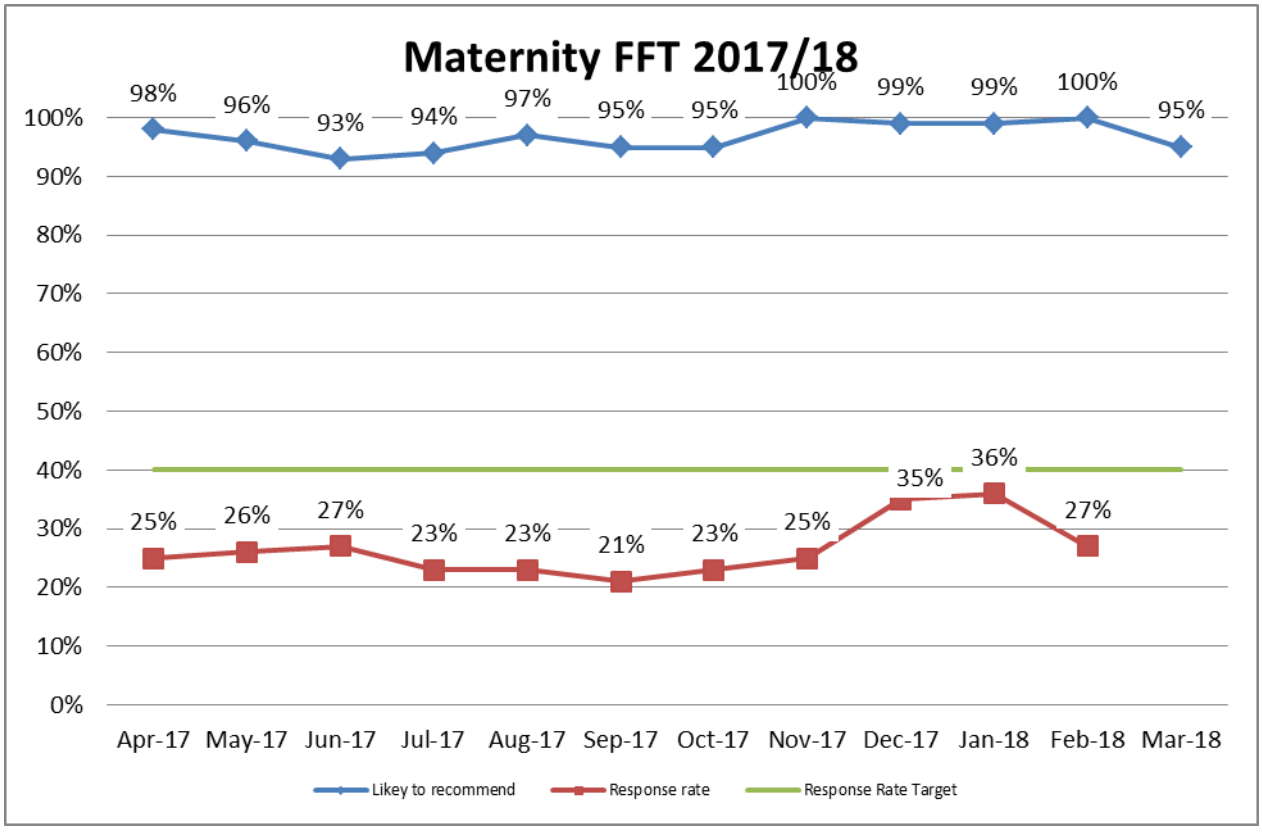
In January the Trust collected 1,074 Friends and family test surveys and then decreased to 788 in February, but there was an increase in the number of responses to 1,288 in March. The Friends and Family Test (FFT) is collected from the inpatient wards, emergency department, maternity unit and outpatient clinics for national submission each month.

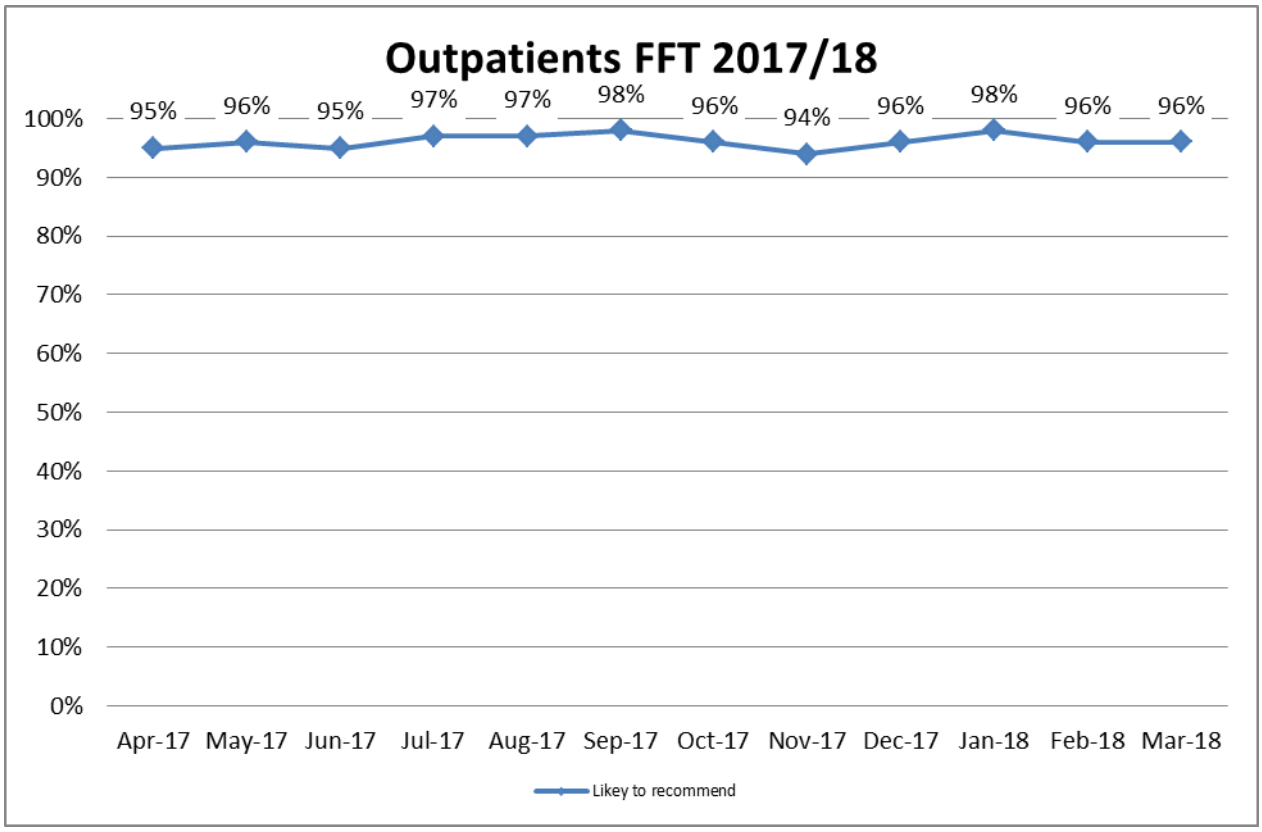
We continue to grow the patient feedback response rate through the use of IwantGreatCare and across the trust knowledge of its use is evident. The recent focus on maternity has shown the average response rate increase for this area from 3% in 2016/17 to 26% in 2017/18, however, work will continue in this area to ensure an increase in the response rate is maintained. The Inpatient/Daycase average response rate for 2017/18 was 31% which has increased from the previous year by 5% and the Emergency Department maintained their response rate of 6% over the last two years.

The following charts show the responses to the friends and family test for each area of submission (Emergency Department, Inpatient Wards, Maternity and Outpatient Clinics).




Inpatient FFT 2017/18
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
96% 95% 97% 94% 95% 95% 98% 96% 93% 94% 95% 96%
31% 50% 27% 39% 32% 31% 36% 20% 33% 24% 19% 26%
Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18
Likey to recommend
Response rate
Response Rate Target


Maternity FFT 2017/18
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
98% 96% 93% 94% 97% 95% 95% 100% 99% 99% 100% 95%
25% 26% 27% 23% 23% 21% 23% 25% 35% 36% 27%
Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18
Likey to recommend
Response rate
Response Rate Target


Outpatients FFT 2017/18
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
95%
96%
95%
97%
97%
98%
96%
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Apr-17
May-17
Jun-17
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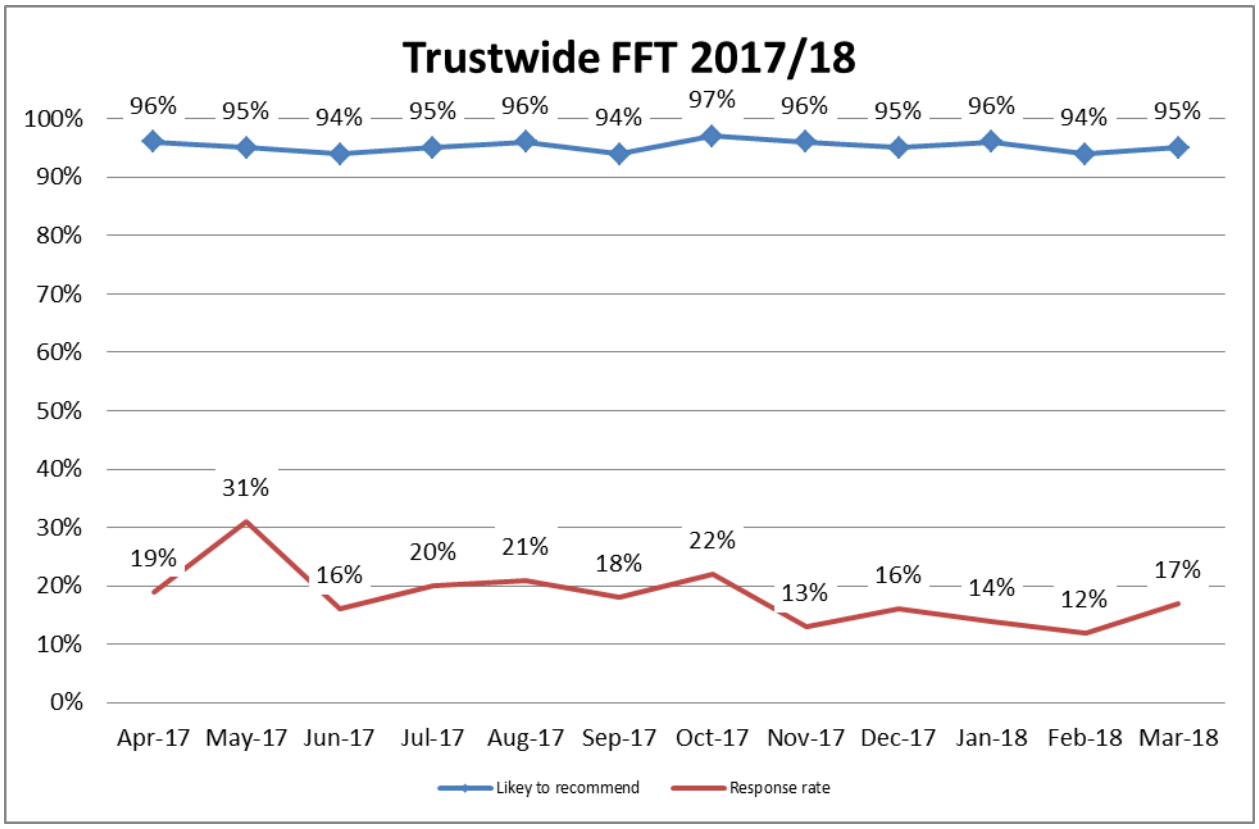
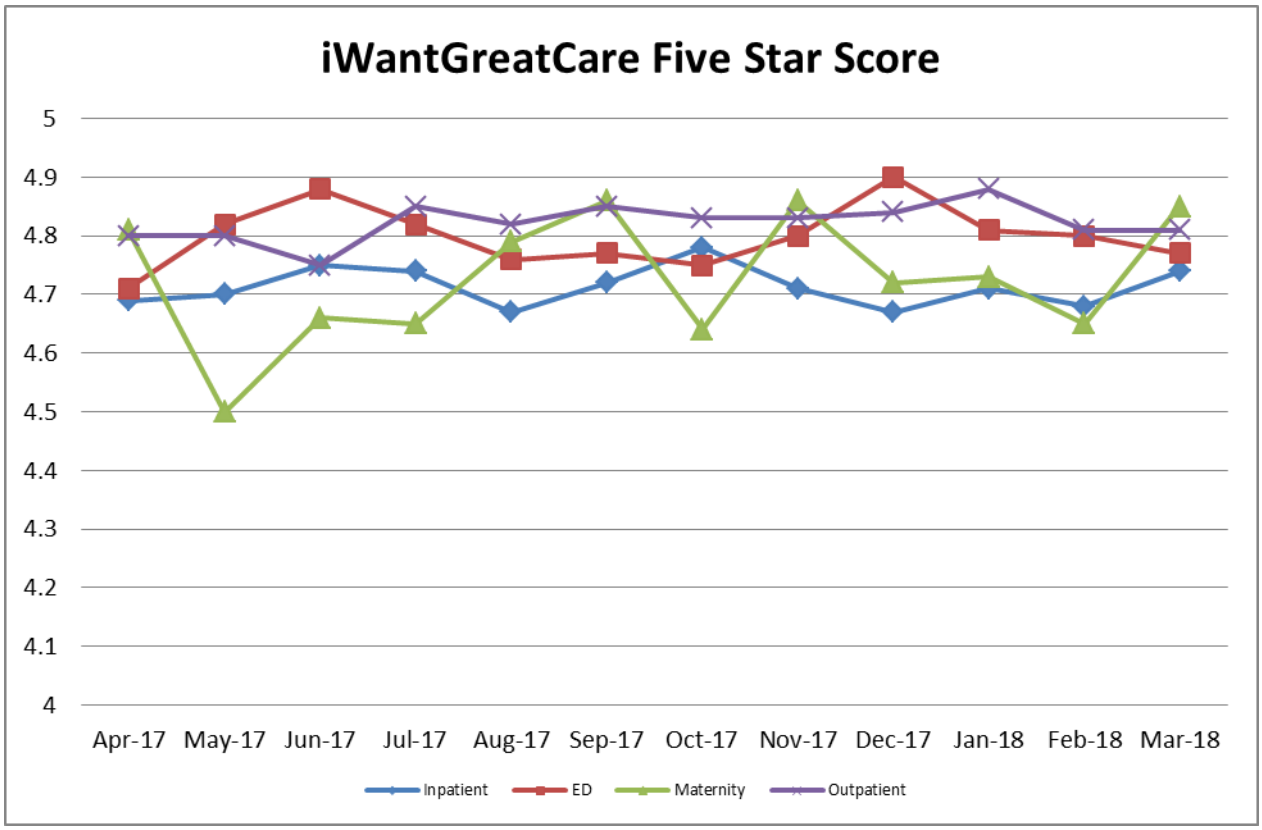
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Likey to recommend



The other questions included in the survey look at whether the patients felt they were treated with dignity and respect and felt involved enough in decisions made about their care, whether they received timely information about their care and treatment, whether the hospital was clean and whether they were treated with kindness and compassion by the staff. The report then provides an average score for the five questions.



As a consequence of the feedback from patients and their families, a number of areas for improvement have been identified that align with the Quality Priorities for 2018/19. These include:

- Development of a Patient and Public Engagement Strategy;
- Increase the percentage response rate for the Friends and Family Test;
- Introduce co-design using Always Events methdology;
- Deliver a Quality Improvement project to support safe and effective discharge.

The programme of improvement work will take place throughout 2018/19 with oversight provieded by the Patient Experience Committee and Integrated Learning Forum. Board level assurance will be via the Governance and Quality Assurance Committee.

Conclusion and Independent Auditor's Report to the Council of Governors of Yeovil District Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Yeovil District Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Yeovil District Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from commissioners, dated 3 May 2018;
- feedback from governors, dated 14 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;

- the latest national patient survey, dated January 2018;
- the latest national staff survey, dated 6 March 2018;
- Care Quality Commission Inspection, dated July 2016.
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Yeovil District Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Yeovil District Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially

different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Yeovil District Hospital NHS Foundation Trust.

Basis for qualified conclusion

Our sample testing for the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways for the year ended 31 March 2018 identified eight issues from a sample of 25 pathways. Our testing noted:

- Two instances where the incorrect start date was used from the referral letter. However, of these two instances, none would change the patient from a non-breach to a breach if the date of the referral letter was taken as the clock start rather than the date the Trust received the letter;
- Two cases where there was no date stamp on the referral letter, hence the clock start date could not be corroborated; and
- Four cases where there was no evidence available to support the clock start date.

Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

29 May 2018

Annex 1 - Statement from the Council of Governors

The Council of Governors receives regular reports on all aspects of quality, including patient safety, clinical outcomes and patient experience. In addition governor observers are invited to attend the Governance and Quality Assurance Committee, the Risk Assurance Committee and Patient Experience and Engagement Group. Governors are also invited to attend the Board of Directors meeting on a rotational basis in addition to being welcomed to attend Part 1 Board of Directors throughout the year. These representatives are actively encouraged to participate and contribute their views, and they report back to the full Council of Governors. On this basis the Governors are confident that the provision of high quality care is a core aim of Yeovil District Hospital and that appropriate measures are in place to monitor standards. The Governors welcome this year's generally positive Quality Accounts which confirm that YDH learns from the data collected and adapts policy accordingly.

Despite the extreme pressures on the NHS system both regionally and nationally, Yeovil District Hospital once more succeeded in achieving performance targets and maintaining standards of care throughout 2017/18. A number of new models of care introduced both within the Trust and South Somerset have assisted in reducing the level of demand and improved the quality of care for patients. The newly implemented services such as HomeFirst have resulted in an impressive reduction in the number of patients recorded as a delayed transfer of care, leading to improvements in patient flow and therefore patient experience.

Yeovil District Hospital worked towards achieving the priorities set for 2017/18 and it is encouraging to see the progress against these. The Trust saw a reduction (29%) in the number of grade two and above pressure ulcers compared to the previous year; this is a very positive position compared to a national level. Infection control figures are also impressive compared to previous years and to other organisations. A reduction of medication related incidents was reported in 2017/18 compared to 2016/17 with the number of incidents reported as "significant" (led to patient harm or required medical intervention) remaining low at 2%. The governors are encouraged to observe that the Trust continues to maintain Safety Thermometer results above 95% throughout 2017/18 with an overall average of 97% of patients being recorded as harm free. The Council of Governors will review the various quality indicators and expects to see further improvement in the coming year.

The governors continued to monitor the Local Indicator of "Proportion of Overnight Discharges 10pm – 7am". The data showed that overnight discharges had small fluctuations throughout the year with a yearly average of 3.2% of total discharges taking place between 10pm and 7am. This was a slight reduction on the previous year however the governors were keen to observe further reductions in 2018/19. There was recognition that a portion of the overnight discharges included those who self-discharged. The Council of Governors intend to keep the proportion of overnight discharges as a priority for 2018/19 and will monitor this accordingly.

The governors received regular information in the lead up to the commencement of Simply Serve Limited, the Trust's wholly owned estates and facilities management company. The governors will monitor the impact and benefits that the creation of this company will provide to the Trust. Further developments of Symphony Healthcare Services and Daycase UK took place in 2017/18 and both these initiatives contribute significantly to improve collaboration between primary and secondary care leading to efficiency of services and improved patient care. The governors welcomed the County Council funding of the rehabilitation beds at

Cooksons Court which further reduce the financial impact on the Trust and provide improved patient flow and experience.

Yeovil District Hospital continues to participate in both national and regional research projects and audits and is keen for continued self-improvement. The Council of Governors welcomes the ongoing improvement shown by the results of the 2017 Staff Survey. The Trust received a response rate of 58%, which places the Trust as one of the highest response rate trusts within the country. The results illustrate that Yeovil District Hospital aims to continuously improve the health and wellbeing of staff and that the organisation responds to feedback from members of staff.

The Council of Governors continues to actively monitor and receive updates on the recruitment of staff, both for medical and nursing staffing groups. Good progress has been observed with regard to nurse recruitment although there are continued challenges with medical recruitment owing to national shortages and delays within the UK visa and immigration process.

The governors welcomed the newly revised Trust's vision statement and strategy which was launched in February 2018. The governors fully support the new vision statement, the iCARE philosophy and the principles of good care which continue to underpin all that the hospital does.

Annex 2 - Statement from the Somerset Clinical Commissioning Group

The Quality Account document is well presented in an easy to read format and gives a clear overview of quality across the organisation. We welcome the Trust's engagement with staff patients and stakeholders in your quality priorities.

Our commissioner statement for inclusion in the Quality Account based on the draft document is below.

NHS SOMERSET CCG COMMISSIONER STATEMENT

As lead Commissioner, NHS Somerset Clinical Commissioning Group (CCG) has reviewed the information provided by the Yeovil District Hospital NHS Foundation Trust Quality Account 2017/18. The Trust has engaged with the CCG in quality monitoring and this provides the basis for the CCG to comment on the Quality Account including the Trust performance against Quality Improvement priorities.

We can confirm that the Quality Account provides a balanced view of the Trusts achievements and as such is an accurate reflection of the quality of services provided. We welcome the Trust's engagement with staff, patients and stakeholders in your quality priorities and the graffiti wall to capture feedback.

Yeovil District Hospital NHS Foundation Trust are to be congratulated on their performance in urgent care and being one of the highest achieving Trusts in the UK for patients being seen within the 4 hour target. The Trust has also been successful in achieving a zero rate of MRSA infection, one of very few in the South West to achieve this.

Our workforce in Somerset remains a priority as good health care is dependent on staff to deliver the care in a safe, responsive and effective way. The staff survey at YDH report 57 % would recommend this a place to work; this is an improvement from last year 52%. The Trust has actively recruited staff from overseas including India and Philippines during 2017/18, however, the staff turnover average for the year remains high at 18.8% and is a concern.

The Trust has a commitment to quality improvement and regularly invites external organisations to review the care they provide through structured reviews such as the Getting It Right First Time programme (GIRFT). In June 2017 the Trust took part in a pilot Care Quality Commission (CQC) and NHS Improvement (NHSI) inspections, YDH was one of four organisations in the pilot nationally. Although the report was not formally published, the Trust received comments on areas for improvement, alongside a number of areas where positive feedback was received.

The CCG are regularly invited to attend the Trust's Internal Quality Assurance Committee and the Trust welcomes the CCG on site visits for planned Assurance visits, Safety Thermometer days and Wards rounds. During the year we have had focused visited to the Emergency Department, Children's ward and Maternity services.

PATIENT EXPERIENCE

The Trust has an ongoing commitment to developing strong patient feedback and implements national and local systems such as the NHS Choices, Friends and Family Test in conjunction with the Trust's iWantGreatCare feedback system. The Trust's Friends and Family response rate remains very low, however, the percentage of patients likely to recommend the Trust remains high at 96%. Despite work to promote the iWantGreatCare

survey, it remains a struggle for the Trust to sustain any improvement in survey participation rates, particularly in A&E.

There are 82 reviews on NHS Choices at the end of April 2018 which rate the Trust overall 4.5 stars out of 5, respondents were positive of caring responsive staff. The National Inpatient Surveys asks the views of adults who stayed the night at the hospital survey. The results last year demonstrated an area of improvement was discharge planning and being involved in decisions. The Trust have been committed during the year to a focus on supporting patients and their family to be more involved in the planning of their discharge. This is an ongoing action in the 2018 survey.

PATIENT SAFETY

The Trust is an active member of the Somerset Pressure Ulcer Collaborative. The Trust has implemented a new approach to monitoring pressure ulcer rates, using trend analysis to link with known activities to identify special cause variation for any improvement or deterioration in pressure ulcer incidence rates. In December 2017 the Trust has 63% less pressure ulcers than in the same period in 2016/17 and a reduction in the rate from 0.66 to 0.30 per 1,000 bed days. The Trust has joined the NHS Improvement Pressure Ulcer Improvement Collaborative which is increasing the application of prevention strategies. This includes for every patient on their locker a copy of the 'Staying Safe in Hospital' leaflet, a return to publishing safety data in public areas of the hospital and mechanisms to generate alerts for staff to raise awareness of high pressure damage risk.

In September 2017 the Trust asked the Royal College of Obstetricians and Gynaecologists (RCOG) to review their Maternity services. The Trust has developed an action plan in light of this review, with the main areas for improvement being on access to Consultants over the 24 hour period; Consultant present at deliveries; and also supporting rotation of staff with another Trust to provide opportunities for staff development.

The overall number of inpatient falls have reduced during 2017, but the rate per 1,000 bed days seems to remain largely unaffected. The CCG notes the focus on increasing actions to reduce falls in bathrooms and toilets and their Dignified Throne Project. This will form part of the ongoing Falls Action Plan Trust wide.

CLINICAL EFFECTIVENESS

The Trust has reported higher than expected mortality rate and a specific alert for deaths from urinary tract infection, the Trust have reviewed all the cases concerned and did not identify and lapses in care. Of the 794 deaths in YDH in the year 157 have been reviewed using a learning tool. The Trust is in the expected range for the Standardised Hospital Mortality Indicator (SHMI) which includes all deaths reported for patients who were admitted and either die while in hospital or within 30 days of discharge.

Mandatory training for Safeguarding Children at Level 3 continues to underperform well below target (95%) with the performance at 69%, the Trust has been consistently below target for the last two years. A review of all staff that require Level 3 Safeguarding Children training has been completed, and a true reflection of staff members who have attended Level 3 training is now available which has shown an increase in the training figures. Level 2 training rate is at 95%. Adults safeguarding training is at 95%.

QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

The CCG supports the quality improvement priorities identified by the Trust for the coming year. The CCG is particularly pleased to see the increased focus on engagement with patients and carers to understand what matters to them to plan their care accordingly.

The CCG has worked with the Trust and partners to plan the Commissioning for Quality innovations (CQUIN) in 2018/19 with a continued support to reducing the impact of serious infections and sepsis for patients, improving services for people with mental health needs who present in A&E and supporting patient focused care.

We look forward to continuing to work with Yeovil District Hospital NHS Foundation Trust during 2018/19 to improve the safety, clinical effectiveness and patient experience of the services provided by the Trust.

Yours sincerely

Sandra Corry

Director of Quality, Safety and Engagement

Annex 3 - Statement from the Dorset Clinical Commissioning Group

In 2017/18 Yeovil District Hospital pursued achievement of key quality priorities and has demonstrated consistency with quality, safety and performance throughout the year by the provision of information at meetings and through reporting mechanisms. NHS Dorset Clinical Commissioning Group can confirm that we believe this Quality Account is an accurate representation of the performance of the organisation during the year.

NHS Dorset CCG recognises the areas of strength described in the Quality Account, such as, the adoption of the structured judgement review (SJR) tool, which has been developed to allow learning to take place from preventable deaths. The report clearly demonstrates the learning that has been taken from this priority and changes that have been implemented.

A Patient Experience and Engagement Lead has been employed to improve the engagement of patients and carers, Dorset CCG supports the need to engage with Patients and the wider community to allow the patient and public voice to be heard and improve the patient experience. The support being provided for carers is also a positive achievement.

The CCG are supportive of the focus of the quality priorities for 2018/19, supporting the emphasise demonstrated in the priorities on patient safety, clinical effectiveness and patient experience. The CCG will continue to work with Yeovil District Hospital and Somerset Clinical Commissioning Group over the coming year to ensure all quality standards are monitored as set out in the reporting requirements of the NHS Contract and local quality schedules.

Annex 4 - Statement of Directors' responsibilities in respect of the quality report

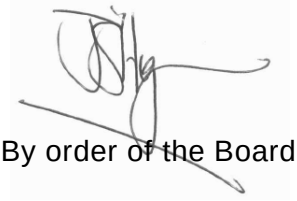
In preparing this annual quality account the Trust's Board of Directors has satisfied itself that the content meets the requirements set out in the NHS Foundation Trust annual reporting manual and supporting guidance.

The content of the report is consistent with internal and external sources of information, including:

- Board minutes and papers between April 2017 and March 2018
- Papers relating to quality reported to the Board between April 2017 and March 2018
- Feedback from the Commissioners
- Feedback from the Governors
  Feedback from local Healthwatch organisations
- The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulation 2009
- The latest national patient surveys
- The latest national staff survey
- The Head of Internal Audit's annual opinion over the Trust's control environment
- CQC quality and risk profiles

The quality report presents a balanced picture of the Foundation Trust's performance over 2017/18. The performance information is reliable and accurate, and there are proper internal controls over the collection and reporting of the performance measure included in the Quality Report. These controls are subject to review to confirm that they are working effectively in practice. The data underpinning the measure of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to 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 Account regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm that to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.



By order of the Board

Annex 5 - Statement from Healthwatch Somerset

Introduction

Healthwatch Somerset welcomes the opportunity to comment on the draft Somerset Partnership NHS Foundation Trust Quality Account for 2017-18. Somerset Healthwatch exists to promote the voice of patients and the wider public with respect to health and social care services. As of 1st October 2017, Healthwatch Somerset came under new management and are therefore are unable to comment on the previous year's activity as it relates to work carried out under the previous Healthwatch Somerset contract.

Although 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 Yeovil District 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 to monitor patient outcomes and to 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 must be a key priority in any hospital and we fully support action to reduce avoidable harm across Yeovil 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. We note the plans to run public engagement events and would welcome the opportunity to be involved with these.

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.

Yeovil District Hospital NHS
NHS Foundation Trust

Consolidated Financial Statements For The Year to 31st March 2018

Contents

Statement of the Chief Executive's responsibilities as the Accounting Officer of Yeovil District Hospital NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Yeovil District Hospital 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 Yeovil District Hospital NHS Foundation Trust and of its income and expenditure, items of comprehensive income and cash flows for the financial year.

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

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of Yeovil District Hospital NHS Foundation Trust and to enable them to ensure that the accounts comply with the requirements outlined in the above mentioned Act. The accounting officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatements whether due to fraud or error and for safeguarding the assets of the Yeovil District Hospital NHS Foundation Trust and hence for taking any reasonable steps for the prevention and detection of fraud and other irregularities. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

Signed

Jonathan Higman, Chief Executive

Date: 25 May 2018

Statement of Directors' responsibilities in respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Independent Regulator of NHS Foundation Trusts, NHS Improvement, in exercise of the powers conferred on Monitor, with the approval of the Treasury, directs that these accounts give a true and fair view of the Foundation Trust's gains and losses, cash flows and financial state at the end of the financial year.

So far as the directors are aware, there is no relevant information of which the Trust's auditors are unaware. The directors have taken all steps that ought to have been taken as a director in order to make themselves aware of any relevant information and to establish that the Trust's auditors is aware of that information.

Signed on behalf of the board:

Jonathan Higman, Chief Executive

Date: 25 May 2018

Independent auditor's report

to the Council of Governors of Yeovil District Hospital NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Yeovil District Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Group and Trust's Statement of Consolidated Comprehensive Income, Statement of Financial Position, Statement of Changes in Tax Payers' Equity, Cash Flow Statement and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2018 and of the Group and Trust's income and expenditure for the year then ended; and
- the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health and Social Care Group Accounting Manual 2017/18.

Material uncertainty related to going concern

We draw attention to note 1.1.2 to the financial statements which indicates that the Group has net liabilities of £22.2 million as at 31 March 2018. The Group is also forecasting a deficit of £21.5 million for the year ending 31 March 2019 and will require ongoing revenue loan support from the Department of Health and Social Care in order to meet the future financial obligations of the Group.

These events and conditions, along with the other matters explained in note 1, constitute a material uncertainty that may cast significant doubt on the Group's and the parent Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview	
Materiality: Group financial statements as a whole	£2.7 million (2017:£2.9 million) 1.9% of total operating income (2016/17: 2.0%)
Materiality: Trust Financial Statements	£2.6 million (2017:£2.6 million) 1.9% of total operating income (2017:2.0%)

Risks of material misstatement		**vs 2017**
Recurring risks	Valuation of Land and Buildings	▲
	Recognition of NHS and non-NHS Income	◄►
Event driven	**New:** Simply Serve Disclosure	▲

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the key audit matters, in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Group's Governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

The first two key audit matters relate to the Group and the parent Trust, while the final key audit matter relates to the parent Trust only.

	The risk	Our response

Land and Buildings
(£57.9 million; 2017: £57.3 million)
 	
Refer to page 23 (Audit Committee Report), page 21 (accounting policy) and page 39 (financial disclosures)
	Subjective valuation - Land and Buildings
	
	Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset.
	
	When considering the cost to build a replacement asset the Trust may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic.
	
	Valuation is complete by an external expert, engaged by the trust using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with interim desktop valuations completed in interim periods.
	
	Valuations are inherently judgemental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied.
	
	Yeovil District Hopsital NHS Foundation Trust had a full valuation undertaken at 31 March 2018, resulting in a £0.2 million increase in the value of the land and buildings.
	
	As the Group completed a full valuation in the current year, we have assessed this as higher risk of material misstatement compared to the prior year audit report.
		Our procedures included:
		
		— **Assessing valuer's credentials:** We considered the scope, qualifications and experience of the Trust's valuers, to identify whether the valuer was appropriately experienced and qualified to undertake the valuation;
		
		— **Our tax expertise:** We used our own tax specialists to considered the appropriateness of the exclusion of VAT from the valuations on the basis that the Group is able to recover VAT on new construction costs through the use of a property management subsidiary;
		
		— **Test of details:** We undertook the following tests of details:
		  — We critically assessed the assumptions used within the valuation by assessing the assumptions used to derive the carrying value of assets against BCIS all in tender price index and industry norms;
		  — We compared the accuracy of the base data used for the carrying value assessment to ensure it agreed to the Group estate;
		  — We considered how the Group had assessed the need for an impairment across its asset base either due to loss of value or reduction in future benefits; and
		  — For a sample of assets added during the year we agreed that an appropriate valuation basis had been adopted when they became operational and that the Group would receive future benefits.
		
		Our findings
		
		— We found the resulting valuation of land and buildings to be balanced.

2. Key audit matters: our assessment of risks of material misstatement

	The risk	Our response
NHS and non-NHS income (£144.9 million; 2017: £141.2 million) *Refer to page 23 (Audit Committee Report), page 20 (accounting policy) and page 31 (financial disclosures).*	**2017/18 Income:** Of the Group's reported income from activities, £120.4 million (2016/17, £115.7 million) came from commissioners (Clinical Commissioning Groups (CCG) and NHS England). Income from CCGs and NHS England make up 81% of the Group's total income. The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then Commissioners are able to impose fines, reducing the level of income from contracts. In 2017/18, the Group received Transformation funding form NHS improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Group was allocated £0.6 million of transformation funding and received additional funding of £1.2 million and the year end. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are produced setting out discrepancies between the submitted balances and transactions between each party, with variances over £300,000 being required to be reported to the National Audit Office to inform the audit of the Department of Health and Social Care consolidated accounts. The Group reported total income of £24.5 million (2016/17: £29.6 million) from other activities principally, Private Patient income, Education and Training and Vanguard project income. Much of this income is generated by contracts with other NHS and non-NHS bodies which are based on varied payment terms, including payment on delivery, milestone payments and periodic payments.	Our procedures included: — **Control observation:** We tested the design and operation of process level controls over revenue recognition; — **Tests of details:** We undertook the following tests of details: ▪ We agreed Commissioner income to the signed contracts and selected a sample of the largest balances (comprising 87% of income from patient care activities) to agree that they had been invoiced in line with the contract agreements and payment had been received; ▪ We inspected invoices for material income in the month prior to and following 31 March 2018 to determine whether income was recognised in the correct accounting period, in accordance with the amounts billed to corresponding parties; ▪ We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers and compared the values they are disclosing within their financial statements to the value of income captured in the financial statements. We sought explanations for any variances over £300,000, and all balances in dispute, and challenged the Group's assessment of the level of income they were entitled to and the receipts that could be collected; ▪ We assessed the transformation funding recorded in the financial statements and the Group's performance against the required targets to confirm eligibility for the income and agreed bonus amounts to correspondence from NHSI; and ▪ We tested material other income balances by agreeing a sample of income transactions through to supporting documentation and/or cash receipts. **Our findings** — We found the resulting estimates of NHS and non-NHS income to be balanced.

2. Key audit matters: our assessment of risks of material misstatement

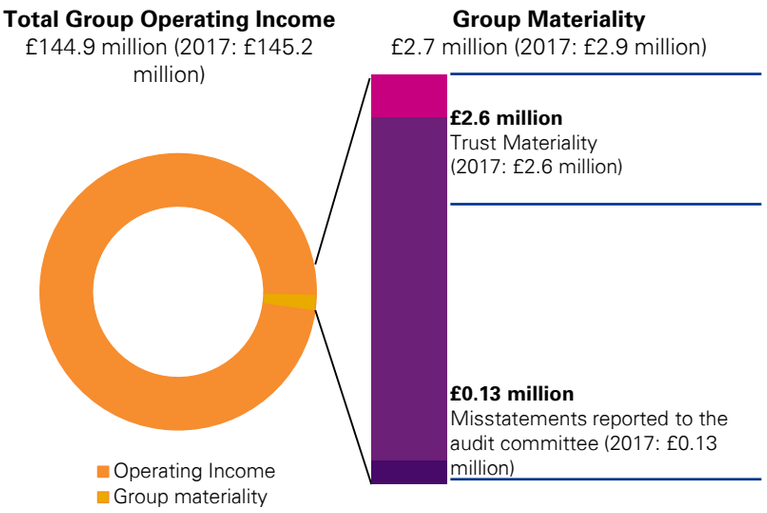
	The risk	Our response
Property Plant and Equipment, Investments, Intercompany Receivables, Intercompany Payables and Loans. (Trust only disclosures) *Refer to page 23 (Audit Committee Report), page 19 (accounting policy) and page 50 (financial disclosures).*	**Accounting treatment** At 1 February 2018, the Group established a new subsidiary company, Simply Serve Limited. The subsidiary will provide managed services for a number of back office function, including the management of the Trust's estate. As part of the agreements the leasehold for the Trust estate was sold to the subsidiary entity, with a corresponding lease of the estate back to the Trust. There is a risk over which entity, the Trust or subsidiary, recognise the estate. There are significant accounting implications of this transaction to ensure that the Trust captures the various elements of the arrangements, which will require appropriate disclosure within the financial statements.	Our procedures included: — **Contract agreement:** We inspected the legal agreements between the Trust and Simply Serve Ltd to understand the substance of the transaction; — **Accounting analysis:** We considered the accounting analysis for the Transaction by assessing the Financial statements to confirm these reflected the underlying nature of the legal agreements; and — **Assessing transparency:** We inspected disclosures made in the Trust financial statements for appropriateness, including which entity recognised the estate. **Our findings** — In determining the accounting treatment of the assets sold to the subsidiary and leased back to the Trust there is room for judgement and we found that within that the Trust's judgement was balanced and the related disclosures were proportionate.

3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £2.7 million (2017: £2.9 million), determined with reference to a benchmark of operating income from continued operations (of which it represents approximately 1.9% (2017: 2%)). We consider operating income to be more stable than a surplus or deficit related benchmark.

Materiality for the parent Trust's financial statements as a whole was set at £2.6 million (2017: £2.6 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.9% (2017: 2%)).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.13 million (2017: £0.13 million, in addition to other identified misstatements that warranted reporting on qualitative grounds.



4. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

5. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 2, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

KPMG

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Other matters on which we report by exception – adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Yeovil District Hospital NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

As at 31 March 2018, the Trust reported a £19.9 million deficit against a forecast outturn position of £17.4 million. The Trust required £58.4 million of revenue support borrowings in year to support the cash position and is expecting to require further borrowings in future periods. The Trust operational plan for 2018/19 forecasts a deficit of £21.5 million (before Transformational Funding), and the Trust does not currently have plans in place to return the Trust to a balanced financial position.

As a result of these matters and the findings on page 10, we are unable to satisfy ourselves that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources..

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Yeovil District Hospital NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risk identified during our risk assessment is set out below together with the findings from the work we carried out on this area.

Significant Risk	Description	Work carried out and judgements
Financial Sustainability	The nature of the financial challenges and underlying deficit, with no medium plans to return to a break even position, presents a significant risk to our assessment of the adequacy of arrangements in place at the Trust.	**Our work included:** — Considering the nature of cash support the Trust is receiving from NHSI and its performance against any conditions attached to the support. — Assessing the Trust's arrangements for managing working capital, including the processes for forecasting and monitoring cash flows and delivering cash savings. — Considering the arrangements in place to deliver recurrent cost improvements by assessing the Trust CIP delivery against the planned CIP target and the use of recurrent and non-recurrent savings. — Comparing the Trust use of agency staff against the agency cap set by NHS Improvement. — Evaluating the Trust position as at 31 March 2018 against the forecast position and considering the future financial plans to assess the ongoing financial sustainability. **Our findings on this risk area:** — As at 31 March 2017 the Trust has reported a £19.9 million deficit against planned deficit of £17.4 million. — The cash balance at year end was £4.6 million, with the Trust requiring £58.4 million of revenue support borrowings in year. — The 2018/19 operational plan forecasts a deficit position of £21.5 million, before transformation funding. The Trust will continue to require revenue funding of in the year to support the cash position, with Department of Health borrowings expected to exceed £60 million by 2018/19 year end. — The Trust delivered £7.2 million of the £8.7 million Cost Improvement Plans for 2017/18, of which £5.3 million are recurrent savings. The plan for 2018/19 includes a CIP of £6.2 million, all of which has been identified. — The Trust has incurred £6.6 million of agency expenditure against an agreed agency cap of £6.5 million. As a result of these matters, we are unable to satisfy ourselves that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Yeovil District Hospital NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Rees Batley

Rees Batley
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
66 Queen Square,
Bristol, BS1 4BE
29 May 2018

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2018 have been prepared by Yeovil District Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed:

Jonathan Higman, Chief Executive

Date 25 May 2018

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

		Group		Trust	
	Note	**2017/18 £'000**	2016/17 £'000	**2017/18 £'000**	2016/17 £'000
Operating income from patient care activities	3	**120,405**	115,652	**113,152**	111,871
Other operating income	4	**24,487**	29,546	**28,052**	25,510
Total operating income		**144,892**	145,198	**141,204**	137,381
Operating expenses	5	**(163,894)**	(156,720)	**(158,241)**	(152,231)
Operating Deficit		**(19,002)**	(11,522)	**(17,037)**	(14,850)
Finance income	9	**27**	31	**200**	19
Finance expenses	9	**(725)**	(885)	**(895)**	(799)
PDC dividends payable		**0**	(309)	**0**	(309)
Net finance costs		**(698)**	(1,163)	**(695)**	(1,089)
Gain on disposal of non-current assets	10	**(68)**	0	**306**	0
Share of profit/(losses) of associates/joint arrangements		**(4)**	991	**(4)**	950
Corporation tax expense		**(46)**	0	**0**	0
Deficit for the year		**(19,818)**	(11,694)	**(17,430)**	(14,989)
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	11	**(552)**	(608)	**(552)**	(608)
Revaluations	15	**522**	2,044	**515**	2,044
Other reserve movements		**173**	0	**173**	0
Total comprehensive expense for the period		**(19,675)**	(10,258)	**(17,294)**	(13,553)
Deficit for the period attributable to:					
non-controlling interests; and		**(102)**	(102)	**0**	0
the Foundation Trust		**(19,716)**	(11,592)	**(17,430)**	(14,989)
Total Deficit		**(19,818)**	(11,694)	**(17,430)**	(14,989)
Total comprehensive income expense for the period attributable to:					
non-controlling interests; and		**(102)**	(102)	**0**	0
the Foundation Trust		**(19,573)**	(10,156)	**(17,294)**	(13,553)
Total comprehensive income expense		**(19,675)**	(10,258)	**(17,294)**	(13,553)

All results relate to continuing operations

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	Note	Group		Trust	
		31 March 2018 £'000	31 March 2017 £'000	**31 March 2018 £'000**	31 March 2017 £'000
Non current assets					
Intangible assets	14	**4,805**	4,333	**4,805**	4,333
Property, plant and equipment	15	**57,900**	57,290	**54,999**	55,512
Investments in associates and joint ventures		**211**	41	**15,149**	144
Trade and other receivables	17	**604**	400	**32,664**	400
Total non current assets		**63,520**	62,064	**107,617**	60,389
Current assets					
Inventories	16	**2,077**	2,027	**1,232**	2,017
Trade and other receivables	17	**13,019**	8,830	**15,839**	8,347
Cash and cash equivalents	18	**4,632**	5,426	**675**	1,200
Total current assets		**19,728**	16,283	**17,746**	11,564
Current liabilities					
Trade and other payables	20	**(23,124)**	(15,178)	**(15,107)**	(14,541)
Borrowings	22	**(18,317)**	(18,461)	**(25,247)**	(18,419)
Provisions	21	**(80)**	(129)	**(80)**	(129)
Other Liabilities		**(245)**	0	**(2,109)**	0
Total current liabilities		**(41,766)**	(33,768)	**(42,543)**	(33,089)
Total assets less current liabilities		**41,482**	44,579	**82,820**	38,864
Non current liabilities					
Trade and other payables	20	**(131)**	(312)	**0**	0
Borrowings	22	**(43,106)**	(26,308)	**(85,786)**	(24,857)
Provisions	21	**(850)**	(1,115)	**(833)**	(1,033)
Total non current liabilities		**(44,087)**	(27,735)	**(86,619)**	(25,890)
Total assets employed		**(2,605)**	16,844	**(3,799)**	12,974
Financed by					
Financed by					
Public dividend capital	25	**42,089**	41,864	**42,089**	41,864
Revaluation reserve		**9,580**	9,402	**364**	9,402
Income and expenditure reserve		**(56,525)**	(37,848)	**(46,252)**	(38,292)
Non-controlling interest		**(204)**	(102)	**0**	0
Charitable fund reserves		**2,454**	3,528	**0**	0
Total taxpayers' & others' equity		**(2,605)**	16,844	**(3,799)**	12,974

The notes on pages 15 – 49 form an integral part of these financial statements

The Annual Accounts were formally approved by the Board of Directors and were signed on its behalf by:

Jonathan Higman – Chief Executive
Date 25/5/18

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 2017/2018

	Total	Charitable Funds	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Non - Controlling Interest
	£'000	£'000	£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2017	16,844	3,528	41,864	9,402	(37,848)	(102)
Deficit for the year	(19,818)	(1,074)	0	0	(18,642)	(102)
Revaluation gains/(losses) and impairment losses property, plant and equipment	(30)	0	0	(30)	0	0
Public Dividend Capital received	225	0	225	0	0	0
Movements on other reserves	173	0	0	208	(35)	0
Total Comprehensive income for the year	(19,450)	(1,074)	225	178	(18,677)	(102)
Taxpayers' Equity at 31 March 2018	**(2,606)**	**2,454**	**42,089**	**9,580**	**(56,525)**	**(204)**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 2016/2017

	Total	Charitable Funds	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Non - Controlling Interest
	£'000	£'000	£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2016	27,061	485	41,823	7,978	(23,225)	0
Deficit for the year	(11,694)	3,057	0	0	(14,649)	(102)
Revaluation gains/(losses) and impairment losses property, plant and equipment	1,436	0	0	1,436	0	0
Transfer to retained earnings on disposal of assets	0	0	0	(12)	12	0
Public Dividend Capital received	41	0	41	0	0	0
Movements on other reserves	0	(14)	0	0	14	0
Total Comprehensive income for the year	(10,217)	3,043	41	1,424	(14,623)	(102)
Taxpayers' Equity at 31 March 2017	**16,844**	**3,528**	**41,864**	**9,402**	**(37,848)**	**(102)**

Information on reserves

NHS charitable funds reserves

This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted.

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health 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 NHS foundation trust.

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2018

		Group		Trust	
		2017/18	2016/17	**2017/18**	2016/17
	Note	**£'000**	£'000	**£'000**	£'000
Cash flows from operating activities					
Operating deficit		**(19,002)**	(11,522)	**(17,853)**	(14,850)
Non-cash income and expense:					
Depreciation and amortisation		**4,132**	4,044	**4,065**	4,038
Net impairments and reversals of impairments		**221**	788	**221**	788
Income recognised in respect of capital donations		**(1,220)**	(780)	**(1,220)**	(780)
Decrease in receivables and other assets		**(4,430)**	(3,685)	**(39,794)**	(3,212)
(Increase)/decrease in inventories		**(50)**	75	**785**	75
Increase/(decrease) in payables and other liabilities		**8,334**	(1,440)	**703**	(1,901)
Increase/(decrease) in provisions		**(315)**	120	**0**	38
Corporation tax (paid)		**(47)**	0	**0**	0
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		**185**	449	**0**	0
Other movements in operating cashflows		**0**	950	**0**	950
Net cash used in operations		**(12,192)**	(11,001)	**(53,093)**	(14,854)
Cash flows from investing activities					
Interest received	9	**16**	19	**15**	19
Payments to acquire intangible assets	14	**(1,138)**	(1,603)	**(1,138)**	(1,603)
Payments to acquire tangible fixed assets	15	**(3,811)**	(6,971)	**(1,830)**	(5,325)
Sale of property,plant and equipment	15	**0**	52	**0**	52
Receipt of cash donatios to purchase capital assets		**0**	780	**0**	780
Net cash used in investing activities		**(4,933)**	(7,723)	**(2,953)**	(6,077)
Cash flows from financing activities					
Public Dividend Capital received	25	**225**	41	**225**	41
Loans received from Department of Health	22	**17,216**	18,745	**17,216**	18,745
Movements on other loans		**(393)**	1,493	**38,782**	0
Interest paid on loans		**(437)**	(750)	**(437)**	(750)
Loans repaid - including finance lease capital		**(143)**	(155)	**(143)**	(155)
Interest element of finance lease		**(88)**	(68)	**(88)**	(68)
Other capital movements		**(89)**	(64)	**(63)**	(64)
PDC dividends received		**29**	(272)	**29**	(272)
Charitable fund financing activities		**11**	12	**0**	0
Net cash used in financing activities		**16,331**	18,982	**55,521**	17,477
(Decrease) / Increase in cash and cash equivalents		**(794)**	258	**(525)**	(3,454)
Cash and cash equivalents at 1 April		**5,426**	5,168	**1,200**	4,654
Cash and cash equivalents at 31 March	18	**4,632**	5,426	**675**	1,200

Notes to the Accounts

1. Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2017/18 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Going concern

In preparation of the year end accounts the Board is required to undertake an assessment as to whether the Trust will continue as a going concern. There is a material uncertainty related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern and that it may therefore be unable to realise its assets and discharge its liabilities in the normal course of business.

The Department of Health Group Accounting Manual (GAM) 2017/18 states that financial statements should be prepared on a going concern basis unless management either intends to apply to HM Treasury for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative to do so.

There has been no application to HM Treasury for the dissolution of the Trust and financial plans have been developed and published for future years. However, as the Trust operated with a deficit from 2015/16 to 2017/18 and has moved to a position of net liabilities with plans of a further financial deficit in 2018/19 the Board did have to consider the material uncertainties within the principle of going concern.

The Trust has received revenue and capital loans from the Department of Health (DOH) with a total value of £60m which enabled the Trust to meet its obligations as they fell due. The 2018/19 financial plans and cash flow forecasts have been prepared on the assumption that further loan support will be received from DOH. This includes loan support to facilitate the repayment of the 2015/16 revenue loan principal of £17.5m which is due to be repaid in January 2019. The loan support planned for would cover the financial deficit after achievement of all savings plans and all performance measures for access to sustainability and transformation funding (STF). Discussions to date indicate all planned funding will be forthcoming, and any cash shortfall resulting from underachievement of savings or STF will be met by further loan facilities. These funds are expected to be sufficient to cover future financial obligations.

The Directors have concluded that there is a reasonable expectation the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. Therefore, these accounts have been prepared under a going concern basis as set out in IAS 1 including critical judgements in applying accounting policies and estimations for uncertainties.

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.

1.1 Consolidation

NHS Charitable Fund

The NHS foundation trust is the corporate trustee to Yeovil NHS Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March 2018 in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

• recognise and measure them in accordance with the foundation trust's accounting policies and

• eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

The Trust wholly owns Symphony Healthcare Services Ltd which forms part of the consolidated accounts. Symphony Healthcare Services Ltd provides primary care services and its turnover for the period ended 31st March 2018 was £8.5m.

The Trust also owns Simply Serve LTD which provides Estates and Facilities services which began trading on 1st February 2018 and its turnover for the period ended 31st March 2018 was £3.7m

The Trust owns Yeovil Property Operating Company LLP which facilitates the provision of GP practice premises and the company was incorporated on 19th January 2016.

The Trust owns 70% of Daycase UK LLP which forms part of the consolidated accounts. Daycase UK LLP provides day surgery procedures, its turnover for the period ended 31st March 2018 was £6.3m.

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Associates

Associate entities are those over which the trust has the power to exercise a significant influence. Associate entities are recognised in the trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g., share dividends are received by the trust from the associate.

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. Joint ventures are accounted for using the equity method.

The Trust has a joint venture with Yeovil Estates Partnership LLP in which it holds 50% of the equity and 50% of the voting rights

The Trust own 15.3% of SW Path Services LLP and holds 20% of the voting rights.

Business Combinations

When acquiring a business from outside the Whole of Government Accounts boundary the trust will account for it in accordance with IFRS 3. Where this is applicable the combination will be accounted for at fair value at the date of combination and any goodwill arising will be accounted for as an asset.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services.

At the year end, the trust accrues income relating to activity delivered in the year, where a patient 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

1.3 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.

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. It is not possible for the NHS foundation trust to identify its share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

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.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when they have been received and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

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 cost of the individual asset is at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All 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 valuation.

Land and property assets are valued 5 yearly with a 3 yearly interim valuation also carried out. Annual desktop valuation reviews are carried out in other years. The 5 yearly and 3 yearly interim valuations are carried out by a professionally qualified valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out on the basis of current value in existing use (as required by HM Treasury) incorporating the approach of using a suitable alternative site in valuing the estate. The annual reviews are conducted using the most appropriate information available at the date of the review. A full valuation was carried out as at 31 January 2018 prior to assets being sold and transferred to Simply Serve Limited.

Equipment assets values are reviewed annually by internal experts to determine the remaining life based on past and forecasted consumption of the economic useful life of the asset.

Assets in the course of construction are valued at current cost. Material assets are valued by professional valuers when they are first brought into use and are subsequently valued as part of the five or three yearly valuations.

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, of which there are currently none.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

The range of useful economic lives are shown in the table below:

	Years
Buildings	9 to 91
Plant and Machinery	5 to 15
Transport equipment	5 to 15
Information technology	5 to 8
Furniture & Fittings	7 to 10

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 PFI contract assets and are not depreciated until the asset is brought into use or revers to the trust, retrospectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset
    - an active programme has begun to find a buyer and complete the sale
    - the asset is being actively marketed at a reasonable price
    - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following the reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs

Donated, government granted and other 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.

1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the 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.

Internally generated goodwill, brands, mastheads publishing titles, customer lists and similar items are not capitalised as intangible assets.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no market exists they are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment. An intangible asset which is surplus with no plan to bring it back into use is valued 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.

	Years
Intangible Assets – Internally generated	5 - 10
Intangible Assets – purchased software	5

1.7 Revenue government grants and other contributions to expenditure

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Governments apprenticeship service is recognised as income at the point of receipt of the training service. When these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition of the benefit.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. Valued at a weighted average cost method. This is considered to be a reasonable approximation to current cost due to the high turnover of inventories.

Inventories are reviewed to enable identification of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles. Obsolete goods are disposed of in line with the Standing Financial Instructions guidance on Disposals and Condemnations, Insurance, Losses and Special Payments.

1.9 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Regular way purchases or sales are recognised and de-recognised, as applicable using the Trade/settlement.

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 'fair value through income and expenditure', loans and receivables.

Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

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 and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

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 assets carrying value and the present value of the revised future cash flows discounted at the assets original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation 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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately

1.11 Provisions

The NHS foundation 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

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 21 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises

1.12 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 24 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 24, 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

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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 NHS foundation 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 NHS foundation 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), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as 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 of the audit of the annual accounts.

1.14 Value added tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation tax

The NHS foundation trust does not have a corporation tax liability for the year 2017/18. Tax may be payable on activities as described below:

- the activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private healthcare falls under this legislation and is not therefore taxable;
- the activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax;
- the activity must have annual profits of over £50,000.

Within the reporting group of Yeovil District Hospital NHS Foundation Trust subsidiary companies will have a corporation tax liability for 2017/18 financial year.

1.16 Foreign exchange

The functional and presentational currencies of the trust are 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.

When accounting for such transactions any gains are losses are recognised through the losses and special payments and disclosed in note 13.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation 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 Financial Reporting Manual.

1.18 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 NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.19 Critical judgements in applying accounting policies

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 financial statements.

Value of land, buildings and dwellings £47.8 million (2016/17 £50.6 million). 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.

Income from patient care activities: Income for an inpatient stay can start to be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying a bed at the 2017/18 financial year end, the estimated value of partially completed spells is £640,215 (2016/17 £619,140).

Accounting standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC:

IFRS 9 Financial Instruments

IFRS 14 Regulatory Deferral Accounts

IFRS 15 Revenue from Contracts with Customers

IFRS 16 Leases

The above amendments and new standards have not yet been adopted within the FReM, and are therefore not applicable to the Department of Health group for 2017/2018. The impact of standards has not yet been fully assessed.

1.20 Accounting standards, amendments and interpretations in issue but not yet effective or adopted

The Trust has not early adopted any new accounting standards, amendments or interpretations.

2.0 Operating Segments

The business activities of the Group can be summarised as that of 'healthcare'. The chief operating decision maker for Yeovil District Hospital NHS Foundation Trust is the Trust Board. Key decisions are agreed at monthly Board meetings and sub-committee meetings of the Board, following scrutiny of performance and resource allocation.

The Trust Board review and make decisions on activity and performance of the group as a whole entity, not for its separate business activities. The activities of the subsidiary companies are not considered sufficiently material to require separate disclosure.

3 Operating income from patient care activities

3.1 Income from patient care activities (by nature)

	Group		Trust	
	2017/18	2016/17	**2017/18**	2016/17
	£'000	£'000	**£'000**	£'000
Clinical Income				
A & E income	**6,341**	5,331	**6,341**	5,331
Community services income	**333**	0	**333**	0
Elective income	**17,072**	20,103	**17,072**	20,103
High cost drugs income	**10,023**	9,968	**10,023**	9,968
Non-elective income	**35,635**	33,761	**35,635**	33,761
Other non protected clinical income	**386**	382	**386**	382
Other NHS clinical income	**31,103**	28,319	**23,987**	24,538
Outpatient income - Firsts	**7,055**	5,959	**7,055**	5,959
Outpatient income - Follow ups	**10,522**	9,726	**10,522**	9,726
Private patient income	**1,935**	2,103	**1,798**	2,103
Clinical income from activities	**120,405**	115,652	**113,152**	111,871

3.2 Income from patient care activities (by source)

	Group		Trust	
	2017/18	2016/17	**2017/18**	2016/17
	£'000	£'000	**£'000**	£'000
CCGs and NHS England	**117,441**	112,637	**110,300**	108,972
Local authorities	**0**	29	**0**	29
Other NHS foundation trusts	**535**	59	**547**	59
NHS other	0	47	**13**	47
Non-NHS: private patients	**1,935**	2,103	**1,798**	2,103
Non-NHS: overseas patients (chargeable to	**108**	23	**108**	23
NHS injury scheme (was RTA)	**386**	382	**386**	382
Non NHS: other	**0**	372	**0**	256
Total income from activities	**120,405**	115,652	**113,152**	111,871
Of which:				

NHS Injury Scheme income is subject to a provision for doubtful debts of 22.84% for 17/18 which has decreased from 22.94% in 16/17 to reflect expected rates of collection.

3.3 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the 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:

Group and Trust

	2017/18	2016/17
	£'000	£'000
Income from services designated (or grandfathered) as commissioner requested services	**118,084**	113,167
Income from services not designated as commissioner requested services	**2,321**	2,485
Total	**120,405**	115,652

3.4 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	Trust	
	2017/18	2016/17
	£'000	£'000
Income recognised this year	**108**	23
Cash payments received in-year	**49**	23
Amounts added to provision for impairment of receivables	**12**	0
Amounts written off in-year	**0**	29

4 Other operating income

	Group		**Trust**	
	2017/18	2016/17	**2017/18**	2016/17
	£'000	£'000	**£'000**	£'000
Research and development	**682**	809	**682**	**809**
Education and training	**4,019**	4,177	**4,019**	**4,177**
Receipt of capital grants and donations	**1,220**	780	**1,220**	**780**
Non-patient care services to other bodies	**3,241**	2,524	**2,956**	**2,524**
Sustainability and Transformation Fund income	**1,834**	5,252	**1,834**	**5,252**
Incoming resources received by NHS charitable funds	**444**	4,038	**0**	**0**
Vanguard project income	**3,435**	3,400	**3,435**	**3,400**
Other income	**9,612**	8,566	**13,906**	**8,568**
Total other operating income	**24,487**	29,546	**28,052**	**25,510**

Included within other income is income relating to catering, staff recharges, car parking, estates recharges and other additional income.

5 Operating expenses

5.1 Operating expenses comprise

		Group		Trust	
		2017/18	2016/17	**2017/18**	2016/17
	Note	**£'000**	£'000	**£'000**	£'000
Clinical negligence insurance		**3,804**	2,883	**3,804**	2,883
Consultancy costs		**923**	377	**913**	353
Depreciation and amortisation		**4,132**	4,044	**4,065**	4,038
Drug costs		**15,349**	14,282	**15,152**	14,282
Establishment		**4,482**	3,021	**3,915**	3,229
Fees for Audit					
- Statutory audit		**59**	56	**59**	56
- Associate Companies		**15**	11	**9**	11
- Other assurance		**7**	7	**7**	7
Internal audit fees		**54**	55	**54**	55
Tax advisory services		**26**	128	**26**	128
Impairments	11	**221**	788	**221**	788
Increase in provisions		**229**	25	**145**	211
Legal fees		**410**	355	**219**	355
Losses, ex gratia & special payments		**43**	0	**43**	0
Loss on disposal of plant, property and equipment		**0**	0	**0**	0
NHS charities expenditure		**1,529**	987	**0**	0
Premises		**8,284**	9,167	**6,962**	8,906
Property, plant & equipment impairments		**0**	0	**0**	0
Purchase of healthcare from non NHS bodies		**3,769**	2,180	**6,844**	2,180
Rentals under operating leases	5.3	**582**	308	**481**	308
Services from:					
- CCGs and NHS England		**575**	0	**0**	0
- NHS Foundation Trusts		**2,741**	3,539	**4,587**	3,539
- NHS Trusts		**453**	0	**0**	0
Staff costs:					
- Executive Directors'	6	**1,310**	1,471	**1,255**	1,471
- Other Staff costs	6	**100,345**	94,509	**90,785**	90,941
- Redundancy costs	6	**553**	1,054	**553**	1,054
- Non-Executive Directors' costs		**117**	104	**117**	104
Supplies and services (excluding drug costs)					
- Clinical		**8,435**	13,368	**7,532**	13,368
- General		**3,073**	2,405	**9,001**	2,305
Training		**437**	590	**427**	590
Transport		**921**	542	**906**	542
Other		**1,016**	464	**159**	527
		163,894	156,720	**158,241**	152,231

5.2 Limitation on auditor's liability

The limitation on the auditor's liability is £2,000,000. (2016/17: £2.0m)

5.3 Operating leases - Yeovil District Hospital NHS Foundation Trust as a lessee

The Group has entered into commercial leases primarily for healthcare equipment.

	Group		Trust	
	2017/18 £'000	2016/17 £'000	**2017/18 £'000**	2016/17 £'000
Operating lease expense				
Minimum lease payments	**582**	308	**481**	308
	582	308	**481**	**308**
Future minimum lease payments due:				
- not later than one year;	**630**	381	**481**	280
- later than one year and not later than five years;	**1,446**	1,228	**968**	600
- later than five years.	**36**	202	**36**	147
Total	**2,112**	1,811	**1,485**	1,027

6 Staff costs

6.1 Staff costs

	Group		Trust	
	2017/18 £'000	2016/17 £'000	**2017/18 £'000**	2016/17 £'000
Salaries and wages (excluding NEDS)	**78,522**	73,434	**71,737**	70,057
Social security costs	**7,517**	6,618	**6,868**	6,620
Employer contributions to NHSPA	**8,707**	8,411	**8,534**	8,483
Termination benefits	**553**	1,054	**553**	1,054
Apprenticeship levy	**348**	0	**348**	0
Agency and contract staff	**6,561**	7,517	**4,553**	7,252
	102,208	97,034	**92,593**	93,466

6.2 Employee benefits

Benefits in kind relating to lease cars totalled £107,561 in the year (2016/17 £92,530). The Trust has introduced a Salary Sacrifice Green Car scheme for employees, these cars are classified as being a Benefit in Kind, the associated costs are covered by the Salary Sacrifice.

7 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 period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of 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 scheme actuary report, 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 their 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 appropriate employee and employer representatives as deemed appropriate.

The actuarial valuation carried out at 31 March 2017 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

8 Retirements due to ill health

During 2017/18 there were no early retirements from the trust agreed on the grounds of ill-health (2016/2017: Three). The estimated additional pension liabilities of these ill-health retirements is nil (2016/17: £96,000).

9 Finance income and expenses

Group and Trust

	2017/18 £'000	2016/17 £'000
Finance Income		
Trust interest received	**15**	19
Charity interest received	**12**	12
	27	31
Finance Expense		
Interest on loan from Department of Health	**(553)**	(731)
Commercial Loans	**(83)**	(75)
Interest on finance leases	**(88)**	(68)
Unwiding of discount on provisions	**(1)**	(11)
	(725)	(885)

10 Gains / losses on disposal/de-recognition of non-current assets

	Group		**Trust**	
	2017/18 £'000	2016/17 £'000	**2017/18 £'000**	2016/17 £'000
Loss on disposal of fixed assets	**(68)**	0	**306**	0
	(68)	0	**306**	0

The disposals in 2017/18 were in respect of non-protected assets.

11 Impairment of assets

Group and Trust

	2017/18 £'000	2016/17 £'000
Changes in market price	**221**	788
Total net impairments charged to operating deficit	**221**	788
Impairments charged to the revaluation reserve	**552**	608
Total net impairments	**773**	1,396

A full revaluation of the Trusts land, buildings and dwellings was carried out as at 31 March 2018.

12 The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts included within interest payable arising from claims made by businesses under this legislation.

13 Losses and special payments

Group and Trust	**2017/18**		2016/17	
	Number	**Value £'000**	Number	Value £'000
Losses of Cash:				
Due to overpayment of salary	**0**	**0**	7	13
Bad Debts				
Private Patients	**0**	**0**	42	4
Overseas Visitors	**1**	**0**	19	29
Other	**10**	**8**	48	3
Damage to building:				
Not theft or fraud	**0**	**0**	1	65
Ex Gratia payments:				
Loss of personal effects	**23**	**9**	40	9
Other	**6**	**26**	10	1
Recovered Losses:				
Compensation Payments Received	**1**	**(65)**	2	(10)
Total losses and special payments	**41**	**(22)**	169	114

There were no case payments that exceeded £100,000.

These amounts are reported on an accruals basis, excluding provisions for future losses

14 Intangible Assets

14.1 Intangible assets at the balance sheet date comprise the following elements

Group and Trust	2017/18 Software licence	2017/18 Assets under construction	2017/18 Total	2016/17 Software licence	2016/17 Assets under construction	2016/17 Total
	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April	**1,649**	**3,996**	**5,645**	1,669	2,455	4,124
Additions - purchased	**100**	**968**	**1,068**	13	1,541	1,554
Additions - leased	**553**	**100**	**653**	0	0	0
Reclassifications	**4**	**(4)**	**0**	0	0	0
Disposals	**(700)**	**(100)**	**(800)**	(33)	0	(33)
At 31 March	**1,606**	**4,960**	**6,566**	1,649	3,996	5,645
Amortisation at 1 April	**1,066**	**246**	**1,312**	777	0	777
Provided during the year	**267**	**328**	**595**	322	246	568
Disposals	**(192)**	**0**	**(192)**	(33)	0	(33)
Amortisation at 31 March	**1,141**	**574**	**1,715**	1,066	246	1,312
Net book value						
- Purchased at 1 April	**583**	**3,750**	**4,333**	892	2,455	3,347
	583	**3,750**	**4,333**	892	2,455	3,347
Net book value						
- Purchased at 31 March	**419**	**4,386**	**4,805**	583	3,750	4,333
Total at 31 March	**419**	**4,386**	**4,805**	583	3,750	4,333

15 Property plant and equipment

15.1 Property, plant and equipment at 31 March 2018 comprise the following elements

Group	Freehold Land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2017	4,357	54,196	1,404	507	16,284	5	2,044	949	**79,746**
Additions - purchased	0	1,010	0	2,057	641	0	519	237	**4,464**
Reclassifications	0	301	0	(391)	90	0	0	0	**0**
Impairments charged to revaluation reserve	0	(2,588)	(16)	0	0	0	0	0	**(2,604)**
Revaluation	285	60	(37)	0	(17)	0	0	(1)	**290**
Disposals	0	0	0	(47)	(465)	0	(151)	(33)	**(696)**
At 31 March 2018	**4,642**	**52,979**	**1,351**	**2,126**	**16,533**	**5**	**2,412**	**1,152**	**81,200**
Depreciation at 1 April 2017	51	8,605	720	0	11,143	5	1,540	392	**22,456**
Provided during the year	0	2,039	59	0	1,162	0	160	117	**3,537**
Impairments	0	347	0	0	0	0	0	0	**347**
Reversal of impairments	0	(2,162)	(16)	0	0	0	0	0	**(2,178)**
Revaluation	0	(189)	(43)	0	0	0	0	0	**(232)**
Disposals	0	0	0	0	(450)	0	(148)	(32)	**(630)**
Accumulated depreciation at 31 March 2018	**51**	**8,640**	**720**	**0**	**11,855**	**5**	**1,552**	**477**	**23,300**
Net book value									
- Purchased at 1 April 2017	4,306	41,996	684	486	4,186	0	504	386	**52,548**
- Finance Leases at 1 April 2017	0	1,329	0	0	279	0	0	0	**1,608**
- Donated at 1 April 2017	0	2,266	0	21	676	0	0	171	**3,134**
Total at 1 April 2017	**4,306**	**45,591**	**684**	**507**	**5,141**	**0**	**504**	**557**	**57,290**
- Purchased at 31 March 2018	4,591	45,556	631	1,065	4,540	5	2,412	492	**59,292**
- Finance Leases at 31 March 2018	0	0	0	0	0	0	0	0	**0**
- Donated at 31 March 2018	0	0	0	(1,061)	(138)	0	0	(21)	**(1,220)**
Total at 31 March 2018	**4,591**	**44,339**	**631**	**2,126**	**4,678**	**0**	**860**	**675**	**57,900**

Trust	Freehold Land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2017	4,306	43,867	684	507	16,255	5	2,005	935	**68,564**
Additions - purchased	0	1,010	0	2,144	647	0	519	41	**4,361**
Additions - leased	3,363	34,895	0	808	5,261	0	459	525	**45,311**
Reclassifications	0	301	0	(391)	90	0	0	0	**0**
Impairments charged to revaluation reserve	0	(2,588)	(16)	0	0	0	0	0	**(2,604)**
Revaluation	285	60	(37)	0	(24)	0	0	(1)	**283**
Sale of Assets (Disposal)	(3,363)	(36,425)	0	(808)	(4,834)	0	(439)	(522)	**(46,391)**
Disposals	0	0	0	(47)	(465)	0	(151)	(33)	**(696)**
At 31 March 2018	**4,591**	**41,120**	**631**	**2,213**	**16,930**	**5**	**2,393**	**945**	**68,828**
Depreciation at 1 April 2017	0	0	0	0	11,122	5	1,533	392	**13,052**
Provided during the year	0	2,004	59	0	1,162	0	160	85	**3,470**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	(1,690)	(16)	0	0	0	0	0	**(1,706)**
Revaluation	0	(314)	(43)	0	0	0	0	0	**(357)**
Disposals	0	0	0	0	(450)	0	(148)	(32)	**(630)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**0**	**11,834**	**5**	**1,545**	**445**	**13,829**
Net book value									
- Purchased at 1 April 2017	4,306	40,271	684	486	4,180	0	472	372	**50,771**
- Finance Leases at 1 April 2017	0	1,326	0	0	279	0	0	0	**1,605**
- Donated at 1 April 2017	0	2,270	0	21	674	0	0	171	**3,136**
Total at 1 April 2017	**4,306**	**43,867**	**684**	**507**	**5,133**	**0**	**472**	**543**	**55,512**
- Purchased at 31 March 2018	4,591	37,587	631	1,043	4,212	0	848	329	**49,241**
- Finance Leases at 31 March 2018	0	1,284	0	0	214	0	0	0	**1,498**
- Donated at 31 March 2018	0	2,249	0	1,083	670	0	0	171	**4,173**
Total at 31 March 2018	**4,591**	**41,120**	**631**	**2,126**	**5,096**	**0**	**848**	**500**	**54,912**

15.2 Property, plant and equipment at 31 March 2017 comprise the following elements:

Group	Freehold Land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2016	4,818	51,820	1,391	1,905	16,891	5	2,091	827	**79,748**
Additions - purchased	0	4,351	0	416	626	0	121	131	**5,645**
Reclassifications	0	1,814	0	(1,814)	0	0	0	0	**0**
Impairments charged to revaluation reserve	(461)	(3,789)	13	0	0	0	0	0	**(4,237)**
Disposals	0	0	0	0	(1,233)	0	(168)	(9)	**(1,410)**
At 31 March 2017	**4,357**	**54,196**	**1,404**	**507**	**16,284**	**5**	**2,044**	**949**	**79,746**
Depreciation at 1 April 2016	51	11,405	769	0	11,088	5	1,582	323	**25,223**
Provided during the year	0	1,987	49	0	1,239	0	126	75	**3,476**
Impairments	0	(1,511)	0	0	0	0	0	0	**(1,511)**
Reversal of impairments	0	(657)	(50)	0	0	0	0	0	**(707)**
Revaluation	0	(2,619)	(48)	0	0	0	0	0	**(2,667)**
Disposals	0	0	0	0	(1,184)	0	(168)	(6)	**(1,358)**
Accumulated depreciation at 31 March 2017	**51**	**8,605**	**720**	**0**	**11,143**	**5**	**1,540**	**392**	**22,456**
Net book value									
- Purchased at 1 April 2016	4,767	37,483	622	1,602	4,884	0	509	404	**50,271**
- Finance Leases at 1 April 2016	0	1,308	0	0	343	0	0	0	**1,651**
- Donated at 1 April 2016	0	1,625	0	303	575	0	0	100	**2,603**
Total at 1 April 2016	**4,767**	**40,416**	**622**	**1,905**	**5,802**	**0**	**509**	**504**	**54,525**
- Purchased at 31 March 2017	4,306	41,996	684	486	4,186	0	504	386	**52,548**
- Finance Leases at 31 March 2017	0	1,329	0	0	279	0	0	0	**1,608**
- Donated at 31 March 2017	0	2,266	0	21	676	0	0	171	**3,134**
Total at 31 March 2017	**4,306**	**45,591**	**684**	**507**	**5,141**	**0**	**504**	**557**	**57,290**

Trust	Freehold Land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2016	4,767	43,180	707	1,905	16,869	5	2,090	826	**70,349**
Additions - purchased	0	2,626	0	416	619	0	83	117	**3,861**
Reclassifications	0	1,814	0	(1,814)	0	0	0	0	**0**
Impairments charged to revaluation reserve	(461)	(3,057)	27	0	0	0	0	0	**(3,491)**
Disposals	0	(696)	(50)	0	(1,233)	0	(168)	(8)	**(2,155)**
At 31 March 2017	**4,306**	**43,867**	**684**	**507**	**16,255**	**5**	**2,005**	**935**	**68,564**
Depreciation at 1 April 2016	0	2,764	85	0	11,068	5	1,581	323	**15,826**
Provided during the year	0	1,987	50	0	1,238	0	120	75	**3,470**
Impairments	0	(1,511)	0	0	0	0	0	0	**(1,511)**
Reversal of impairments	0	(771)	(71)	0	0	0	0	0	**(842)**
Revaluation	0	(2,469)	(64)	0	0	0	0	0	**(2,533)**
Disposals	0	0	0	0	(1,184)	0	(168)	(6)	**(1,358)**
Accumulated depreciation at 31 March 2017	**0**	**0**	**0**	**0**	**11,122**	**5**	**1,533**	**392**	**13,052**
Net book value									
- Purchased at 1 April 2016	4,767	37,483	622	1,602	4,884	0	509	404	**50,271**
- Finance Leases at 1 April 2016	0	1,308	0	0	343	0	0	0	**1,651**
- Donated at 1 April 2016	0	1,625	0	303	575	0	0	100	**2,603**
Total at 1 April 2016	**4,767**	**40,416**	**622**	**1,905**	**5,802**	**0**	**509**	**504**	**54,525**
- Purchased at 31 March 2017	4,306	40,270	684	486	4,180	0	472	372	**50,770**
- Finance Leases at 31 March 2017	0	1,327	0	0	279	0	0	0	**1,606**
- Donated at 31 March 2017	0	2,270	0	21	674	0	0	171	**3,136**
Total at 31 March 2017	**4,306**	**43,867**	**684**	**507**	**5,133**	**0**	**472**	**543**	**55,512**

16 Inventories

	Group		Trust	
	31 March 2018 £'000	31 March 2017 £'000	**31 March 2018 £'000**	31 March 2017 £'000
Drugs	**1,072**	965	**1,138**	1,022
Consumables	**1,003**	1,060	**92**	991
Energy	**2**	2	**2**	4
	2,077	2,027	**1,232**	2,017

Inventories recognised in expenses for the year were £50,000 (2016/17: £152,000). Consumables of £730,000

qa were transferred

17 Trade and other receivables

17.1 Trade and other receivables

	Group		Trust	
Current	**31 March 2018 £'000**	31 March 2017 £'000	**31 March 2018 £'000**	31 March 2017 £'000
Amounts falling due within one year:				
NHS receivables	**2,725**	1,080	**2,641**	840
Provision for impaired receivables	**(307)**	(80)	**(307)**	(80)
Prepayments	**2,277**	926	**958**	911
Accrued income	**5,738**	5,255	**6,366**	4,704
PDC dividend receivable	**0**	29	**0**	29
Amount owed by group undertakings	**0**	0	**4,225**	0
Other receivables	**2,586**	1,620	**1,956**	1,943
	13,019	8,830	**15,839**	8,347
Non-Current				
Amounts falling due after more than one year:				
Provision for impaired receivables	**(157)**	(176)	**(157)**	(176)
Amount owed by group undertakings	**0**	0	**32,060**	0
Other receivables	**761**	576	**762**	576
	604	400	**32,665**	400
Total receivables	**13,623**	9,230	**48,504**	8,747

17.2 Provision for the impairment of receivables

	Group		Trust	
	31 March 2018 £'000	31 March 2017 £'000	**31 March 2018 £'000**	31 March 2017 £'000
At 1 April	**256**	344	**256**	344
Increase in provision	**225**	79	**225**	79
Amounts utilised	**63**	(157)	**63**	(157)
Unused amounts reversed	**(80)**	(10)	**(80)**	(10)
At 31 March	**464**	256	**464**	256

An allowance for impairment is made where there is an identifiable event which, based on previous evidence that the monies will not be recovered in full.

17.3 Analysis of impaired receivables

	Group		Trust	
	31 March 2018 £'000	31 March 2017 £'000	**31 March 2018 £'000**	31 March 2017 £'000
Ageing of impaired receivables				
0 - 30 days	**0**	0	**0**	0
30 - 60 days	**0**	0	**0**	0
60 - 90 days	**3**	0	**3**	0
90 - 180 days	**304**	18	**304**	18
over 180 days	**157**	158	**157**	158
	464	176	**464**	176

18 Cash and cash equivalents

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.

	Group		Trust	
	31 March 2018 £'000	31 March 2017 £'000	**31 March 2018 £'000**	31 March 2017 £'000
At 1 April	**5,426**	5,168	**1,200**	4,654
Net change in year	**(794)**	258	**(525)**	(3,454)
At 31 March	**4,632**	5,426	**675**	1,200
Broken down into:				
Cash at commercial banks and in hand	**609**	329	**106**	109
Cash with the Government Banking Service	**4,023**	5,097	**569**	1,091
Total cash and cash equivalents as in SoFP & SoCF	**4,632**	5,426	**675**	1,200

19 Third Party Assets

The Trust had cash at bank and in hand at 31 March 2018 £2,018 (£1,995 at 31 March 2017) in relation to monies held by the Foundation Trust on behalf of patients.

20 Trade and other payables

	Group		Trust	
	31 March 2018 £'000	31 March 2017 £'000	**31 March 2018 £'000**	31 March 2017 £'000
Amounts falling due within one year:				
Receipts on account	**0**	357	**0**	357
NHS payables	**2,355**	688	**668**	688
Trade payables - capital	**520**	1,157	**520**	1,157
Other trade payables	**5,227**	3,159	**2,831**	3,054
Other payables	**5,098**	863	**2,260**	811
Amount owed to group undertakings	**0**	0	**622**	0
Accruals	**9,504**	8,466	**8,206**	8,474
NHS Charitable funds payables	**420**	488	**0**	0
Total current payables	**23,124**	15,178	**15,107**	14,541
Amounts falling due after one year:				
Other trade payables	**131**	312	**0**	0
Total non current payables	**131**	312	**0**	0
Total payables	**23,255**	**15,490**	**15,107**	**14,541**

Other trade payables include £986,661 in respect of outstanding pensions contributions as at 31 March 2018 (2017/18 £1,278,000).

21 Provisions for Liabilities and Charges

Group and Trust	Pensions relating to other staff £'000	Legal Claims £'000	Other £'000	Total £'000
At 1 April 2017	244	918	82	**1,244**
Arising during the year	71	5	23	**99**
Change in discount rate	0	75	0	**75**
Utilised during the year	(315)	(78)	(6)	**(399)**
Reversed unused	0	(8)	(82)	**(90)**
Unwinding of discount	0	1	0	**1**
At 31 March 2018	**0**	**913**	**17**	**930**
Expected timing of cashflows:				
Within 1 year	0	80	0	**80**
1 - 5 years	0	222	17	**239**
over 5 years	0	611	0	**611**
	0	**913**	**17**	**930**

£59,323,658 is included in the provisions of the NHS Litigation Authority at 31 March 2018 in respect of clinical negligence liabilities of the Trust, (£58,703,670 for 2016/17).

21.1 Pensions relating to other staff

The cost of pensions relating to early retirements is calculated using The NHS Pension Agency capitalisation tables for the NHS Pension Scheme to determine the full liability for each employee.

21.2 Legal Claims

The provision is based on information provided by the NHS Litigation Authority and refers to non-clinical claims against the Trust.

21.3 Estimation uncertainty

Amounts recorded under provisions for “Pensions relating to other staff” and “Legal Claims” include an element of uncertainty as the provision has been calculated using the English Life Expectancy statistics to estimate the length of time the liability can reasonably be expected to remain.

22 Borrowings

	Group		Trust	
	31 Mar 2018	31 Mar 2017	**31 Mar 2018**	31 Mar 2017
	£'000	£'000	**£'000**	£'000
Current				
Department of Health loans	**18,143**	18,091	**18,143**	18,091
Other Loans	**27**	42	**4,601**	0
Intercompany finance lease	**0**	0	**2,355**	0
Obligations under finance leases	**147**	328	**148**	328
Total current borrowings	**18,317**	18,461	**25,247**	18,419
Non-current				
Department of Health loans	**40,818**	23,654	**40,818**	23,654
Other Loans	**1,072**	1,451	**0**	0
Intercompany finance lease	**0**	0	**43,753**	0
Obligations under finance leases	**1,215**	1,203	**1,215**	1,203
Total non-current borrowings	**43,105**	26,308	**85,786**	24,857

Department of Health loans have various interest rates depending ranging from 0.5% - 1.5% with the first revenue repayment falling due in January 2017 for £17.5m.

The trust also has an intercompany finance lease with Simply Serve LTD that started on the 1st February 2018 this has an interest rate of 3.45% totalling £46.1m.

22.1 Investments in Subsidiary Undertakings

Trust

	2017/18	2016/17
	£'000	£'000
Shares in subsidiary undertakings	**15,149**	555
Loans to subsidiary undertakings > 1 year	**32,060**	0
	47,209	555
Loans to subsidiary undertakings < 1 year	**1,396**	0
Total	**48,605**	555

22.2 Finance Leases

	Group		Trust	
	31 Mar 2018	31 Mar 2017	**31 Mar 2018**	31 Mar 2017
	£'000	£'000	**£'000**	£'000
Gross Leases Liabilities	**1,623**	1,846	**67,208**	1,846
Not later than one year	**197**	201	**4,106**	201
Later than one year less than five years	**597**	725	**16,766**	725
Later than five years	**829**	920	**46,337**	920
Finance charges allocated to future periods	**(261)**	(315)	**(19,738)**	(315)
Net lease liabilities	**1,362**	1,531	**47,471**	1,531
Of which is payable				
Not later than one year	**147**	328	**2,504**	328
Later than one year less than five years	**472**	357	**11,286**	357
Later than five years	**743**	846	**33,681**	846
	1,362	1,531	**47,471**	1,531

23 Capital Commitments

There is £156,962 of capital commitments at 31 March 2018. (31 March 2017 £419,700). This is made up of the following:

Mechanical Works £114,000

Replacement of life expired plant

Other Capital Projects of £43,000 include:

Other commitments relate to redesign of OPD following the addition of the Modular Unit, electrical works and the implementation of Imessage which is a link from the Fire Alarm to allow Voice calls & text messaging.

24 Contingent Assets and Liabilities

There were no contingent assets and no contingent liabilities for the year ended 31 March 2018 or for the year ended 31 March 2017.

25 Movements in Public Dividend Capital

Group and Trust	**2017/18**	2016/17
	£'000	£'000
Public dividend capital at 1 April	**41,864**	41,823
New public dividend capital received	**225**	41
Public dividend capital at 31 March	**42,089**	41,864

26 Related party transactions

Yeovil District Hospital NHS Foundation Trust is a body corporate established by the issue of a licence of authorisation from Monitor.

The Trust is under the common control of the Board of Directors. 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 Yeovil District Hospital NHS Foundation Trust.

During the year ended 31 March 2018, Yeovil District Hospital NHS Foundation Trust has had a significant number of material transactions with other entities for which the Department of Health is regarded as the parent department as well as transactions through subsidiary companies and joint ventures. These entities are listed below:

2017/2018	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000
Dorset County Hospital NHS FT	149	350	74	114
Dorset University Healthcare NHS FT	579	445	11	551
Royal Devon and Exeter NHS FT	586	240	6	370
Gloucestershire Hospitals NHS FT	0	590	0	594
Somerset Partnership NHS FT	2,968	865	910	129
Taunton and Somerset NHS FT	1,093	1,568	415	392
Health Education England	3,454	0	0	0
Dorset CCG	15,893	0	208	56
Somerset CCG	85,760	697	832	435
Wiltshire CCG	287	0	17	0
NHS England (excluding STF)	10,972	103	536	406
NHS England (STF)	3,573	0	1,190	16
NHS Resolution	0	3,804	0	0
Southwest Pathology Services (JV)	0	1,786	0	0
SPS Facilities (JV)	0	1,658	0	0
Integrated Pathology Services	276	0	0	0
Daycase UK (DCUK)	5,878	6,326	1,924	887
Simply Serve LTD	272	3,561	42,717	50,735
Symphony Healthcare Services	350	111	350	0

2016/2017	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000
Dorset County Hospital NHS FT	151	308	13	116
Dorset University Healthcare NHS FT	1,752	397	273	90
Royal Devon and Exeter NHS FT	611	340	0	185
Gloucestershire Hospitals NHS FT	0	662	0	61
Somerset Partnership NHS FT	2,521	647	174	67
Taunton and Somerset NHS FT	573	1,416	167	29
Health Education England	4,045	0	0	0
Dorset CCG	14,815	0	7	0
Somerset CCG	85,193	224	109	75
Wiltshire CCG	334	0	18	0
NHS England (excluding STF)	15,288	108	1,073	367
NHS England (STF)	5,252	0	2,196	0
NHS Resolution	0	2,883	0	0
Southwest Pathology Services (JV)	0	1,768	0	0
SPS Facilities (JV)	0	1,878	0	0
Integrated Pathology Services	270	0	0	0
Daycase UK (DCUK)	663	483	333	0

In addition, the Trust has entered into transactions with other Government Departments and other central and local Government bodies.

The Trust has also received revenue and capital payments from a number of charitable funds. Some of the Trustees of these charitable funds are also members of the Board of the NHS Foundation Trust. Full audited accounts are prepared for the Funds held on Trust.

27 Group Structure

Simply Serve Limited – Company Number: 10847254

Registered office – Yeovil District Hospital, Yeovil, Somerset, BA21 4AT

Simply Serve Ltd (SSL) was incorporated on 3 July 2017 and became operational on 1 February 2018. Simply Serve Ltd is 100% owned by Yeovil District Hospital NHS Foundation Trust.

SSL has been set up to support the Trust's strategic objectives, improve efficiency and develop more cost effective ways of working. SSL provides a full range of professional estates and facilities services along with IT, procurement and financial services to Yeovil District Hospital NHS Foundation Trust and other clients. Around 350 staff transferred under TUPE regulations to Simply Serve Ltd on 1 February 2018.

The key objectives of establishing SSL are as follows:

- Maintain and improve quality of services
- Free up Trust management to focus on healthcare
- Develop a more efficient and cost effective service
- Retain staff within the YDH group providing opportunities and security
- Enhance the ability to recruit and retain key staff groups
- Enhance focus and flexibility on developing additional income generation opportunities

SSL operates as an arm's length organisation with its own board of directors and governance structure. Services are provided under contractual arrangements with detailed service specifications and key performance indicators.

Simply Serve Ltd will be submitting dormant accounts for the period 3 July 2017 to 31 December 2017 and has adopted a long accounting period from 1 January 2018 to 31 March 2019 to align accounting periods with the parent company.

Symphony Healthcare Services Ltd – Company Number: 06633460

Registered office – Wynford House, Yeovil, Somerset, BA22 8HR

During 2016/17 Yeovil District Hospital NHS Foundation Trust acquired Pathways Healthcare and Social Care Alliance Ltd, the company was renamed to Symphony Healthcare Services Ltd.

As at 31st March 2018 Symphony Healthcare Services operates primary care services at eight locations within Somerset, Ilchester GP practice, Yeovil health centre, Buttercross Health Centre, Highbridge Medical Centre, Crewkerne Health Centre, St Lukes Medical Centre, Oaklands Surgery and Wincanton Health Centre.

Yeovil District Hospital NHS Foundation Trust owns 100% of the equity and no goodwill arose in respect of the acquisitions. As per the NHS Act 2006 section 259 no goodwill can arise as part of the sale of primary care businesses.

	£000's
Consideration paid	153
Net Assets Aquired	(153)
Goodwill	**0**

Post the balance sheet date of 31st March 2018 Symphony Healthcare Services Ltd acquired Hamdon Medical Centre on 1st May 2018, no goodwill arose on acquisition, this company will be included within the consolidated financial performance at 31st March 2019.

Daycase UK LLP – Company Number: OC2412071

Registered office – 7 Lindum Terrace, Lincoln, Lincolnshire, LN2 5RP

During 2016/17 Yeovil District Hospital NHS Foundation Trust established Daycase UK LLP for the purpose of delivering more efficient day case surgery. The company is a partnership with Ambulatory Surgery International Ltd.

The company was incorporated on 1st June 2016, Yeovil District Hospital NHS Foundation Trust owns 70% of the company.

Yeovil Estates Partnership LLP – Company Number: OC396172

Registered office – 5 The Triangle, Worcester, Worcestershire, WR5, 2QX

During 2014/15 Yeovil District Hospital NHS Foundation Trust procured a Strategic Estates Partner and as a result established the Joint Venture Yeovil Estates Partnership LLP to undertake strategic estates activity on behalf of the Trust.

Yeovil Estates Partnership LLP was established on 29th October 2014. Yeovil District Hospital NHS Foundation Trust owns 50% of the equity of Yeovil Estates Partnership LLP and holds 50% of the voting rights.

No goodwill arose in respect of the subsidiary as the reporting Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

Wellchester Innovation Limited – Company Number: 10405218

Registered office – Yeovil District Hospital, Yeovil, Somerset, BA21 4AT

Wellchester Innovation Ltd was incorporated on 1st October 2016. Since the date of incorporation the only accounting transaction has been the payment for shares taken by subscribers to the memorandum of association. The company has incurred no other accounting transactions in the accounting period.

As such being dormant since incorporation it is entitled for audit exemption and qualifies for dormant company accounts.

Yeovil Property Operating Company Ltd – Company Number: 09958551

Registered office – Yeovil District Hospital, Yeovil, Somerset, BA21 4AT

Yeovil District Hospital NHS Foundation Trust established a subsidiary company, Yeovil Property Operating Company Ltd to facilitate the provision of GP practice premises. The company was incorporated on 19th January 2016, Yeovil District Hospital NHS Foundation Trust owns 100% of Yeovil Property Operating Company.

Southwest Pathology Services LLP – Company Number: OC370482

Registered office – 1 Kingdom Street, London, W2 6BD

The associate is Southwest Pathology Services LLP incorporated in the United Kingdom with its principle place of business being Somerset.

Southwest Pathology Service LLP provided pathology testing for the Trust and other clients up until 28 February 2015. From 1 March 2015 it provides the analytical elements of pathology testing for the Trust and other clients and is expected to continue to do so for the long term.

Yeovil District Hospital NHS Foundation Trust owns 15.3% of the equity of Southwest Pathology Services LLP and holds 20% of the voting rights on matters not requiring unanimous consent of members as identified within the contractual arrangements.

SPS Facilities LLP – Company Number: OC397788

Registered office – 1 Kingdom Street, London, W2 6BD

The associate is SPS Facilities LLP incorporated in the United Kingdom with its principle place of business being Somerset.

SPS Facilities LLP was established 1 March 2015 and provides the facilities elements of pathology testing for the Trust and other clients and is expected to continue to do so for the long term.

Yeovil District Hospital NHS Foundation Trust owns 15.3% of the equity of SPS Facilities LLP and holds 20% of the voting rights on matters not requiring unanimous consent of members as identified within the contractual arrangements.

SW Path Services LLP – Company Number: OC383198

Registered office – 1 Kingdom Street, London, W2 6BD

The associate is SW Path Services LLP incorporated in the United Kingdom with its principle place of business being Somerset.

Yeovil District Hospital NHS Foundation Trust owns 15.3% of the equity of SW Path Services LLP and holds 20% of the voting rights on matters not requiring unanimous consent of members as identified within the contractual arrangements.

28 Financial Instruments

IAS 32 (Financial Instruments, Presentation), IAS 39 (Financial Instruments: Recognition and Measurement) and IFRS 7 (Financial Instruments, Disclosure) require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Due to the way that the Commissioners are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities.

Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

29 Financial Risk Management

The Trust's financial risk management operations are carried out by the Trust's Treasury Function, within the parameters formally defined within the Treasury Management Guidance, agreed by the Trust Audit Committee. Trust treasury activity is routinely reported and is subject to review by internal and external auditors.

The Trust's financial instruments comprise of cash and liquid resources and various items such as trade debtors and creditors that arise directly from its operations. The Trust does not undertake speculative treasury transactions.

29.1 Liquidity Risk

The NHS Foundation Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. Yeovil District Hospital NHS Foundation Trust has submitted an annual plan to its regulator Monitor for 2017/18 which plans for a £13.5m deficit; the Trust expects to receive cash support from the Department of Health during the year in order for it to be able to meet its cash commitments.

29.2 Interest Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest rate risk.

29.3 Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

29.4 Credit Risk

The majority of the Trust's income comes from Government bodies or other NHS organisation under contractual arrangements meaning that the Trust is not exposed to high levels of credit risk.

Other income is subject to credit control procedures which are regularly reviewed by management. Outstanding debtors are referred to a credit collection agency once the Trust has exhausted all other methods of collection.

29.5 Price Risk

The Trust invests its surplus cash in Government Banking Services Accounts (GBS) therefore it is not subject to market price risk.

29.6 Cashflow Risk

Cash is invested in accordance with approved procedures. Cashflows are monitored and weekly forecasts are produced to ensure commitments are met.

29.7 Financial Assets

Group	**Carrying Amount 31 Mar 2018**	**Fair Value 31 Mar 2018**	Carrying Amount 31 Mar 2017	Fair Value 31 Mar 2017
	£'000	**£'000**	£'000	£'000
Trade and other recievables	**11,085**	**11,085**	8,830	8,830
Cash at bank	**4,634**	**4,634**	5,426	5,426
	15,719	**15,719**	14,256	14,256

29.8 Financial Liabilities

Group	**Carrying Amount 31 Mar 2018**	**Fair Value 31 Mar 2018**	Carrying Amount 31 Mar 2017	Fair Value 31 Mar 2017
	£'000	**£'000**	£'000	£'000
Borrowings	**60,061**	**60,061**	41,745	41,745
Finance Lease	**1,363**	**1,363**	1,531	1,531
Other creditors	**23,124**	**23,124**	16,963	16,963
Provisions	**930**	**930**	1,244	1,244
	85,478	**85,478**	61,483	61,483

Fair value is not significantly different from book value since, in the calculation of book value, he expected cashflows have been discounted by the Treasury discount rates.