NHS

Annual Report, Quality Account and Annual Accounts 2018/19

Yeovil Hospital Healthcare

Yeovil District Hospital NHS Foundation Trust

Annual Report, Quality Account and Annual Accounts 2019/20

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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), 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

Yeovil District Hospital is situated in Somerset, which is a largely rural county with a population of 550,000. The population of Somerset is relatively older than the national average, and over the next 25 years, the number of people over the age of 75 is expected to double. Whilst people in the region are living longer than they used to, there is an ever-increasing gap between life expectancy and healthy life expectancy with increasing numbers of people living longer with one or more complex long-term conditions. At the present time, approximately one third of the population has at least one long-term condition – this equates to 175,000 people in Somerset. This is a key driver of the significant rise in demand for health and care services across all providers within the county.

In 2018/19, there have been continuing unprecedented levels of demand across the sector, and this has been reflected at Yeovil District Hospital. 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. Compared to 2017/18, Yeovil District Hospital has experienced a 10.4% year-on-year increase in emergency department attendances.

During 2018/19, Yeovil District Hospital was one of a small number of trusts in the country that continued to maintain performance across the range of key performance standards including routinely being within the top five of acute trusts for its accident and emergency waiting times performance throughout the year. Further information on performance indicators and constitutional standards can be found on page 10 onwards.

In addition, the 2018 staff survey results reflected the positive culture that exists at Yeovil District Hospital. The Trust had the highest recorded response rate for any hospital in the country – 71 per cent compared to a national average of 44 per cent. The results put Yeovil District Hospital as the highest performing trust in the country for staff health and wellbeing. Furthermore, Yeovil District Hospital is also in the top 20 per cent of NHS trusts for a number of other areas within the staff survey, including diversity and inclusion; support from managers; staff morale; safety of the hospital environment; and staff engagement. More information on the staff survey results can be found on page 49.

The Trust is actively engaged as a key partner in the Somerset Sustainability and Transformation Partnership (STP). Through this, the *Fit for my Future* (FFMF) programme has recognised the growing challenges across the healthcare system and the need to ensure that the various parts of the health and care system work more closely together. The ambition is to reduce the number of people becoming ill and mitigate the growth rate in accident and emergency attendances and emergency admissions across Somerset. Where people do become ill, the FFMF programme aims to ensure that people can get access to joined up health and care support in the community, away from hospitals where possible, to help them live independently for as a long as they can.

A number of priority areas for change across the Somerset health and care system have been identified with the aim to address the main challenges faced. These priority areas include:

- preventing avoidable disease and promoting and enabling physical and mental wellbeing;
- tackling inequalities – services are not yet configured to address the greatest areas of need which are often driven by wider inequalities;
- providing holistic, integrated locality-based care;
- supporting independence and reducing dependency;
- ensuring promotion and support of people's mental health and well as their physical health;
- ensuring viable specialist and inpatient services; and
- addressing the Somerset system health and care system financial challenges.

The Trust does face significant challenges with regard to finances. Due to the scale of the deficit financial position for Yeovil District Hospital and the wider Somerset system, a review was undertaken during 2018 by NHS Improvement that aimed to identify and quantify the key deficit 'drivers'. The resulting report outlined that the drivers of the deficit within the Somerset system could be split between the following categories:

- Operational drivers: essentially these relate those items solely within the control of a single organisation, for example internal productivity and efficiency;
- Strategic drivers: these relate to items relating to the scale and/or configuration of services currently being provided or variation in the pattern of demand across our system; and
- Structural drivers: underlying issues relating to the rural nature of Somerset or traditional ways that services are funded.

For Yeovil District Hospital, the review quantified drivers totalling between £15.7million and £18.2million. These are broadly split 60% operational and strategic (within the control of the Trust working within the local system) and 40% structural. The report provides the context and focus for actions address the Trust's deficit over the coming year. As a result of external reviews, the Trust has significantly changed its approach to CIP delivery for 2019/20, refocussing effort on a series of more traditional CIP schemes, but in parallel launching a major clinical efficiency and productivity programme. Benchmarking data from the Model

Hospital, Getting it Right First Time (GIRFT) and the Trust's own internal patient level costing system are being triangulated to identify the major areas of focus.

This programme was launched in mid-March 2019 and builds on the Trust's strong culture as recognised by both the recent Care Quality Commission's inspection and the 2018 Staff Survey. The Trust believes that the strength of cultural engagement at Yeovil District Hospital provides a springboard for dial changing action in 2019/20. The Executive team aims to lead the entire team on a journey towards optimum efficiency and productivity, leading to further improved outcomes and making Yeovil District Hospital an even better place to work. An NHS Improvement (NHSI) Use of Resources inspection took place in January 2019 as part of the Trust's Care Quality Commission inspection. The recommendations from this report have been amalgamated into a comprehensive action plan and are due to be implemented over the coming months. Further information on efficiency and effectiveness of the use of resources can be found on page 62.

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 Clinical Commissioning Group, Somerset County Council and local GPs as part of the Somerset STP, which is currently in the stages of developing an integrated care system (ICS). Key to the development of an ICS is the need to work increasingly close with local general practice. To this end, Yeovil District Hospital established Symphony Healthcare Services, a primary care wholly owned subsidiary, which is now supporting thirteen practices though a new management model.

Yeovil District Hospital recognises that there may be a potential impact from the United Kingdom's decision to leave the European Union, especially concerning the Trust's workforce and subsequently the ability to provide safe care for patients. Staff employed from the European Union are invaluable to the organisation and help the Trust provide safe and compassionate care for patients. The impact on morale with EU staff following the decision to leave the European Union is difficult to quantify, however the Trust has provided support and guidance to all staff members employed from the European Union. Yeovil District Hospital has not seen a significant number of leavers as a consequence of the United Kingdom's decision to leave the EU.

There are a number of associated risks in relation to leaving the European Union, including EU staff being subject to new immigration rules; it is possible that restrictions will be put into place making it more challenging for the Trust to recruit from the European Union. This could potentially pose a risk to patient care and affect the operational performance and effectiveness of the hospital. There is also a less obvious risk that EU staff may feel less welcome in the UK and therefore may decide to return to their home country, even though they have a legal right to work in the United Kingdom. A number of mitigating actions have been launched, including writing to all EU staff within the Trust and providing support and guidance to ensure that they feel valued and supported. The Trust has via NHS Employers, lobbied the government to ensure that visa restrictions are not placed on NHS workers. The Trust's overseas recruitment campaigns in Dubai and the Philippines provide some additional resilience and is therefore less likely to be impacted than other trusts.

Outside of the workforce related risks, the Department of Health and Social Care has undertaken a number of national preparations to mitigate risks, particularly regarding drugs and stock entering the United Kingdom. This includes holding stock centrally and creating new supply routes from Europe. A comprehensive action plan has been developed outlining key actions to mitigate risks the Trust faces in the event of a no-deal exit. These risks include potential implications in relation to reciprocal healthcare for citizens, which could result in increasing numbers of UK citizens returning to the United Kingdom for healthcare

treatment. Clinical research and trials could also be affected although the Trust does not currently have any European Union grants or trials in place.

It is currently difficult to estimate the possible increase in direct costs relating to the exit from the European Union, however planning and mitigating actions have led to indirect costs from staff time across the Yeovil District Hospital group. The financial implications and the resulting action plans will be maintained and monitored as government negotiations on leaving the European Union continue.

Vision and Strategy

Yeovil District Hospital's vision and strategy of the organisation are shown below with the four strategic objectives supported by a clear set of organisational priorities.

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.

2019 Strategic Priorities

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
Strategic priorities	**Strategic priorities**	**Strategic priorities**	**Strategic priorities**
• Refresh our clinical strategy and ensure alignment with STP plans. • Demonstrate outstanding standards of care. • Deliver national A&E and cancer standards. • Support the Somerset system to reduce overall elective waiting times and improve RTT performance. • Fully embed end of life care planning. • Improve the way we learn from avoidable harm. • Improve mental health care with a particular focus on the care of dementia and CAMHS.	• Build on our positive 2018 staff survey, with a focus on reducing violence and aggression towards our staff • Significantly reduce our staff agency usage with particular focus on medical agency. • Refresh iCARE in order to underpin our positive culture. • Review our clinical leadership model. • Develop a clinical workforce strategy to reflect our revised clinical strategy. • Continue to improve staff retention. • Improve our GMC survey results.	• Review our estates masterplan, focussing on our emergency and day surgery services. • Refresh and align our digital transformation strategy with the Trust clinical strategy. • Improve the basic level of IT across the Trust. • Implement ePrescribing and expand eObservations. • Establish our Business Intelligence strategy, including a 'single source of the truth' for the Somerset ICS. • Collaborate on the delivery of the SIDER project and countywide digital programmes. • Support the development of local 'Neighbourhoods' and Primary Care Networks, including the relaunch of the South Somerset Care Board.	• Meet our control total and CIP target for 2019/20. • Demonstrate improved financial 'grip', including the roll out of PLICS. • Refresh our focus on improving efficiency and productivity using best practice tools. • Embed Quality Improvement Methodology across the Trust • Transform SHS to be financially independent. • Develop a plan for Simply Serve Ltd to support back office consolidation. • Continue progress towards a Somerset Integrated Care System.

In March and April 2019, the Trust's vision and strategy of the organisation were reviewed in order to ensure that this suitably reflects the ambition of the organisation. The updated vision and strategy is an evolution of the previous versions, and links closely to the Trust's iCARE values with a core focus on patient care, experience whilst ensuring that resources are responsibly managed for the sustainability of services within Yeovil District Hospital and the local care system.

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 twelve 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

2018/19 Performance Summary

Yeovil District Hospital reviewed and updated its Quality Improvement Strategy for 2019-2021, which outlines the areas of focus for quality improvement. The review of the strategy for 2019-2021 considered and built upon the previous strategy in its deliberations, as well as national reports including recommendations from:

- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013)
- A promise to learn – commitment to act: improving the Safety of Patients in England (Berwick, 2013)
- A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture (Clywd, 2013)
- Cavendish Report (Cavendish, 2013)
- Safer Staffing Requirements: Safe Staffing for adult inpatients in acute care (2018),
- Better Births, Improving outcomes of maternity services in England
- The Morecambe Bay Investigation (Kirkup, 2015)
- The regulatory requirements of the Duty of Candour
- The Care Act (2015).
- Learning, candour and accountability: A review of the way Trusts review nad investigate the deaths of patients in England (Care Quality Commission, 2017)
- National guidance on Learning from Deaths for Trusts (National Quality Board, 2017)
- Working with Families, (NHS Improvement, 2018)

The strategy incorporates national recommendations, including safe staffing, considers system wide challenges, STP ambitions 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. Improving access to high quality end of life care remains a priority.

The Care Quality Commission undertook an inspection visit at Yeovil District Hospital between 4 December 2018 and 17 January 2019 the report was published on 8 May 2019. While the overall rating remains unchanged, inspector noted clear progress in a number of areas since the previous inspection and in two domains, the highest Outstanding rating was

achieved. The hospital's core services were rates as Good for being effective, caring, responsive and well-led. The hospital was rated as Requires Improvement under the safe domain. The Care Quality Commission published the Trust's Use of Resources report at the same time, which is based on an assessment undertaken by NHS Improvement. The Trust has been rated as Inadequate for using its resources productively. The combined rating for the Trust, taking in account the Care Quality Commission's inspection for the quality of services and NHS Improvement's assessment for Use of Resources, is Requires Improvement.

The hospital was pleased to receive an overall 'Good' rating overall for core clinical services.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Outstanding ↑↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Medical care (including older people's care)	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Surgery	Requires improvement Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Critical care	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Maternity	Good Apr 2019	Good Apr 2019	Outstanding Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Services for children and young people	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
End of life care	Requires improvement ↓ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Outpatients	Good Jul 2016	N/A	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Overall*	Requires improvement →← Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019

This rating comprised of 36 ‘good’ or ‘outstanding’ ratings in a total of 39 inspection themes. Patients attending our hospital to receive care or treatment from any of these services can therefore do so confident that we are meeting or exceeding national benchmarks for hospital services. Whilst the overall assessment of all core hospital services is ‘Good’ – the second best rating available from CQC – we are also delighted that two of our services achieved the highest possible ‘Outstanding’ results in certain areas.

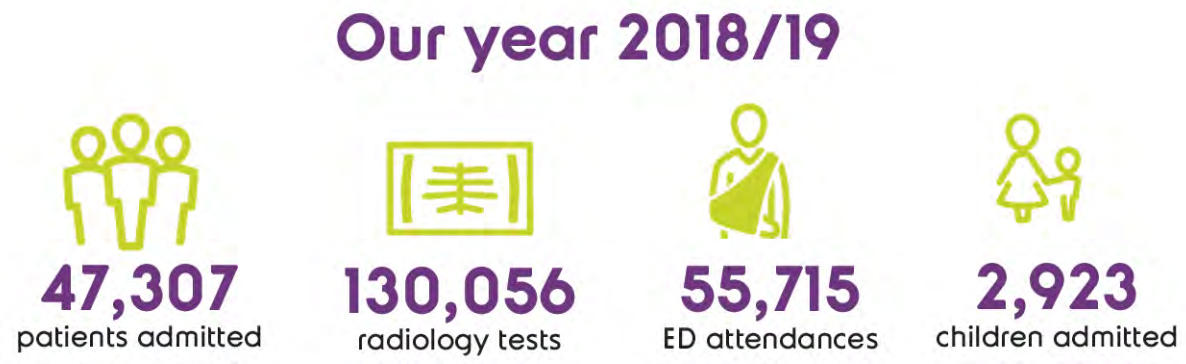
For our urgent and emergency services, which were previously rated as ‘Requires Improvement’ by the CQC, the rating of ‘Good’ across every element of this latest inspection was further enhanced by an assessment of ‘Outstanding’ for the responsiveness of the care. These excellent results were mirrored in our maternity services, which were previously rated as ‘Requires Improvement’ by the CQC, with ‘Good’ ratings across the board and an ‘Outstanding’ for caring. Comments from the CQC about the compassion and person-centred care exhibited by these services are proof of the enviable quality of our maternity team.

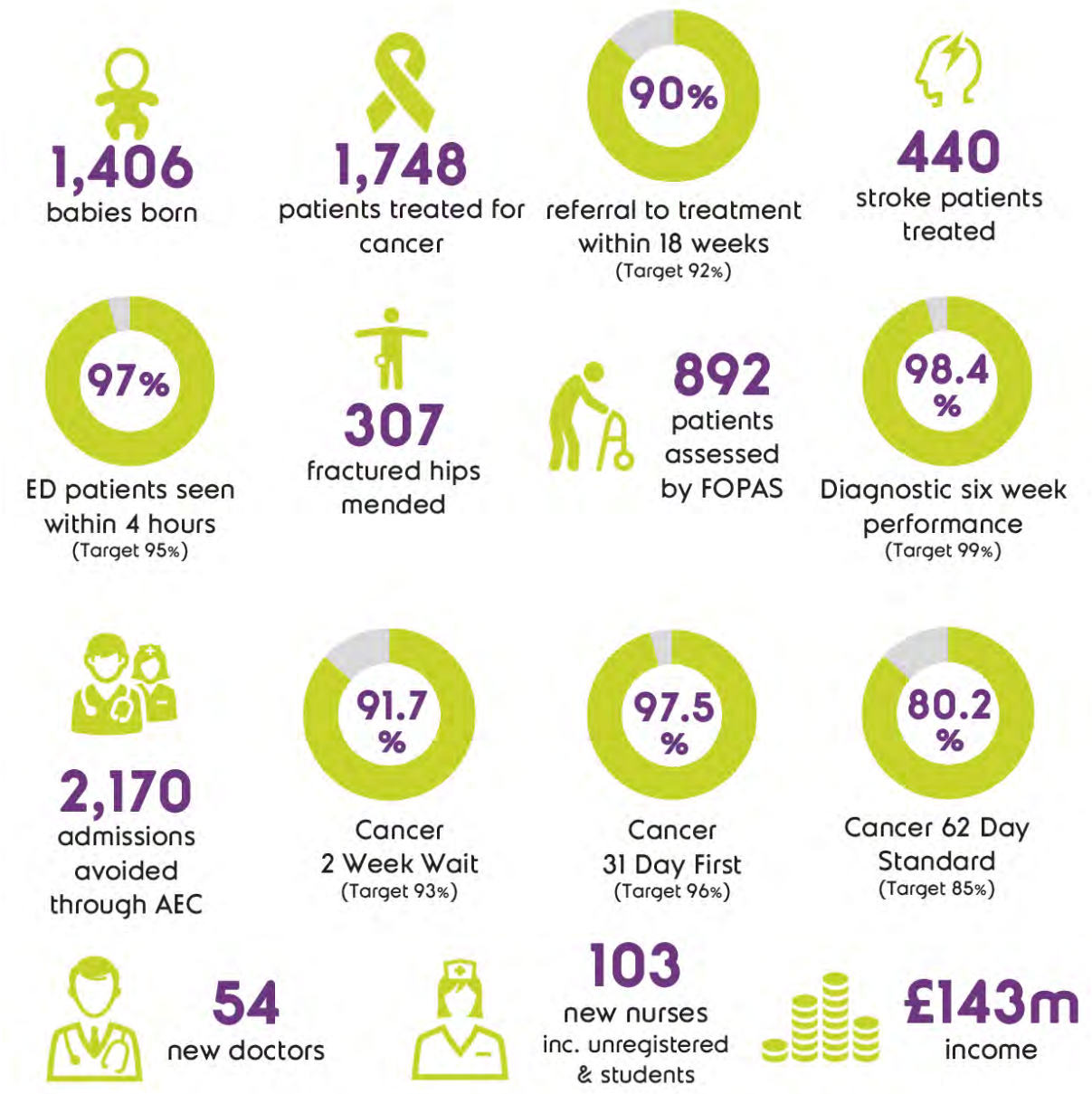
It is important to clarify the reasons behind the ratings given against the safe domain, which relate to technical aspects of the service and do not, in themselves, suggest clinical risk to patients. The Care Quality Commission noted certain areas where it would like to see greater clarification, evidence or improvement, including the need for greater consistency in record keeping and changes to the support provided for children and young people with mental health issues, and work is already underway to address these issues.

Upon publication of the reports, Jonathan Higman, Chief Executive, said: “Our staff should be proud of the improvements we have made to our services which have resulted in this ‘Good’ rating for clinical services. To transform the ratings for patient care and services in the way we have over the past three years is an exceptional achievement and testament to the expertise, passion and dedication of the entire workforce.”

Dr Nigel Acheson, CQC’s Deputy Chief Inspector of Hospitals, said: “Yeovil District Hospital NHS Foundation Trust has worked incredibly hard to embed the improvements we requested from our previous inspections and I want to congratulate the trust for the work done and for its consistent work with other organisations to improve the services offered to the local community.”

Yeovil District Hospital continues to receive positive feedback through a variety of methods including the iWantGreatCare (iWGC) survey. As of 31 March 2019, the Trust had a star rating of 4.87 (out of a best possible score of 5).





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 four-hour A&E waiting times target across the year. The hospital's A&E department saw a significant increase in the number of people attending compared to previous years, with 55,715 patients in 2018/19 compared to 50,446 in the previous year. This equates to an increase of 10.4%. The Trust is expected to continue to achieve the target in 2019/20. In 2018/19, 97.3% of patients were seen and either discharged or admitted within four hours against the 95% target set by NHS England. Yeovil District Hospital is consistently in the top five hospitals in the country for performance against this standard.

Although at year-end Yeovil District Hospital did not achieve the national 92% target set for Referral to Treatment (RTT) ongoing patient pathways waiting less than 18 weeks, the Trust does benchmark well against other organisations on both a regional and national scale. For 2018/19, performance for the number of ongoing pathways waiting times was 90.5%. The underperformance of the target was driven by increasing demand across a number of specialties including cancer services. No patients were waiting over 52 weeks for treatment.

Strong performance had been maintained for diagnostic waiting times although there had been some fluctuations during quarters two and three of 2018/19. Diagnostic six-week waiting time performance as of 31 March 2019 was 99.7% against the 99% target. Significant improvements have been made with regard to diagnostic capacity, especially with MRI scanning, with the usage of additional portable scanning services. In endoscopy, the Trust has provided additional capacity through the appointment of new nurse endoscopists roles. This has stabilised performance within the service. The Trust has also filled a consultant pathologist vacancy leading to improved pathology reporting times; this significantly improves the ability to treat patients within the 62-day timeframe.

Demand for cancer services is ever increasing and places significant challenge on acute trusts across the region. Due to this increasing demand, there had been fluctuations in performance at Yeovil District Hospital, in particular against the 62-day standard, largely as a direct result of patient choice, increasingly complex pathways and clinical decisions. Yeovil District Hospital's 62-day standard performance was 80.2% against the 85% target for 2018/19. Full recovery plans are undergoing revision to shift the Trust to achieving the national targets throughout 2019/20 with improvements seen in cancer performance targets in quarter four of 2018/29.

Yeovil Hospital is consistently rated as a high performer against the range of national indicators. This continued good performance is testament to the commitment and dedication of our staff and volunteers.

The Trust has continued to experience a significant financial challenge during 2018/19. The Trust did not achieve its financial control total, a target that is agreed each year with our regulators, for the year 2018/19. The Trust realised a deficit for 2018/19 of £21.4m compared to the control total, which was agreed with NHS Improvement, of £19.9m; this is a variance of £1.5m. The variance is consistent with a re-forecasting exercise undertaken at Month 6. The deficit for 2018/19, after accounting for Provider Sustainability Funding and donated asset income, was £18.3m. The Trust has been able to finance this deficit through loan funding agreed with the Department of Health and Social Care, which is the standard procedure.

For 2019/20, there is potential for Yeovil District Hospital to access additional central funding, such as Marginal Rate Emergency Rule (MRET), Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF). As such, a break-even control total for 2019/20 has been agreed with regulators. The draft Trust budget for 2019/20 is set to achieve the NHS Improvement control total of break-even through cost efficiencies and £19.3m of non-recurrent central funding. The plan was submitted following collaboration with the Somerset Sustainability and Transformation Partnership, which is working on a recovery plan to address the system deficit. In order to meet the control total, demanding cost improvement plans amounting to a target of £5.7m, are required. In setting the CIP plans for 2019/20, the Board has been clear that it must set realistic targets that do not detrimentally affect the safety and/or quality of care. Plans have been informed through an assessment of potential opportunities using the NHS Improvement Model Hospital tool. They cover a range of areas including but not limited to:

- Back office efficiencies: predominantly targeting corporate workforce in the hospital and Symphony Healthcare Services and non-pay (indemnity) savings in Symphony Healthcare Services;
- Clinical operational efficiency: seeking opportunities (both workforce and non-pay) to improve the efficiency and productivity of our services and continue our drive to reduce medical and nursing agency spend;
- Estate efficiencies: a mixture of projects aiming to drive efficiencies from the areas of catering, cleaning, IT, waste disposal etc.;

- A vacancy freeze on positions that do not affect patient safety and quality; and
- Procurement: achieve savings using the Supply Chain new model and more efficient product/price decisions.

The Board recognises the significant challenge regarding the Trust's deficit financial position and is committed to work to address the key drivers of the deficit through its own internal focus on efficiency and productivity. It will also work collaboratively with local partners to ensure a system response to the countywide deficit position and address the key strategic issues that the deficit drivers report identifies. The Somerset STP acknowledges that the county's health and care services are not keeping pace with demand and the changing needs of local people and that the Somerset system requires radical transformation to ensure its financial and clinical sustainability.

A number of key deliverables for the Somerset system have been identified for 2019/20, including:

- Improving access to elective care in the west of the county and move towards more equitable access of services across the county. The agreed ambition is for the elimination of over 52-week waiters and ensuring performance equalisation across Somerset.
- Investing in core mental health services, recognising the current level of investment and service gaps, and implement universal support services for children and adults aimed at mitigating specialist demand.
- Developing and implementing a set of changes to acute services and acute pathways including agreeing proposals for longer-term changes.
- Development of local services through the establishment of neighbourhood teams across Somerset. The Trust will work with the Clinical Commissioning Group and primary care partners to focus resources away from acute services and into community alternatives and services that support patients to stay well in their own homes, or as close to home as possible, Through this, the aim is to reduce demand on acute services over time.

The key deliverables outlined above will have an effect on Yeovil District Hospital. In order to improve access to elective care in the west of the county and move towards more equitable access of services across the county, referrals from a geographical area between Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital will be directed to Yeovil. This system wide approach and the associated trajectory reflects a system agreement to maintain a minimum 82% Referral to Treatment waiting time performance at Yeovil District Hospital. This will largely be across referrals for suspected hernia, or suspected gall bladder problems, patients requiring cataract procedure and patients requiring a major joint procedure.

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 through the Board of Directors, which meet eight times a year. Further scrutiny takes place within the Governance and Quality Assurance Committee, the Financial Resilience and Commercial Committee and the Workforce Committee on a monthly, bi-monthly or a 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 that are addressed by the paper. These risks may be recorded on the corporate risk register and/or departmental risk registers.

Following a project to strengthen the internal operational performance reporting and assurance process, the remit of the Hospital Management Team meeting was revised. This meeting includes the executive teams, business managers and clinical directors who review Trust wide 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

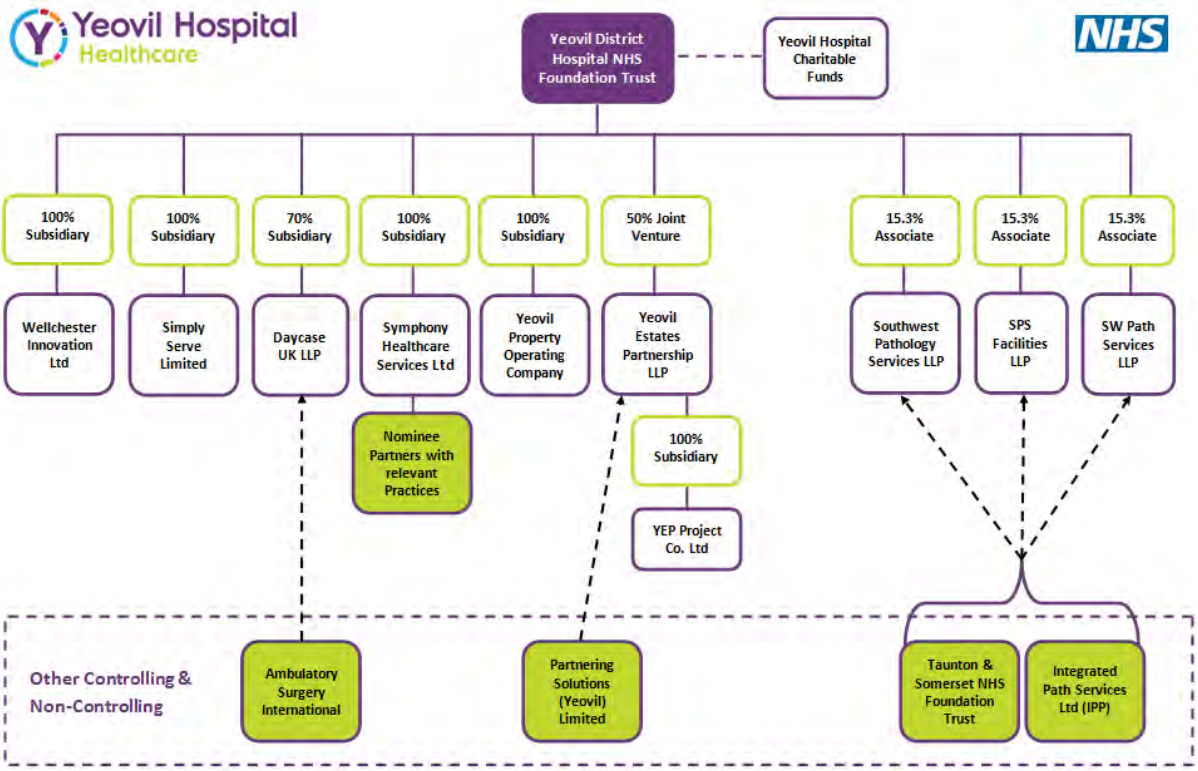
Yeovil District Hospital has a number of joint ventures and subsidiary companies. Joint ventures are separate entities over which Yeovil District Hospital has joint control with one or more other parties. The meaning of control is where the Trust has the power to exercise control or a dominant influence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

Yeovil District Hospital owns a proportion of the following joint ventures and associates:

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

The group structure can be seen below:



Simply Serve Limited: 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. 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.

Simply Serve Limited's overall performance during its first 14 months of operation has grown in strength with financial targets being exceeded and key service metrics showing strong performance. The organisation has grown its profitable customer base and service offering. Courier services have been established and provide a higher quality service at a lower cost to the Trust. Maintenance, compliance and other services are provided to a number of customers including the GP practices operated by Symphony Healthcare Services Limited.

All necessary accreditation for the performance of high quality, effective services has been achieved and maintained along with achievement of the Cyber Essentials accreditation. Simply Serve Limited continues to drive efficiency and utilise technology to provide enhanced cost effective services. A new group wide printing solution has been implemented providing greater security at reduced cost, a portering management system is being implemented and an equipment tracking solution is under consideration.

Symphony Healthcare Services Limited: Symphony Healthcare Services was a critical part of the national 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. Data provided by the Somerset Commissioning Support Unit provides a strong case for success of the new care models within South Somerset; this

includes most of the Symphony Healthcare Services practices. Detailed analysis demonstrates that practices within Symphony Healthcare Services have a rate/1000 less than other South Somerset practices for overnight emergency admissions. There is variation across the practices due to the different demographics and stages in maturity into the new care models. Other initiatives are being introduced to further reduce admissions, including in January 2019, Buttercross Health Centre and Ilchester Surgery commencing an acute on the day service with the aim of reducing their rate of emergency admissions into Yeovil District Hospital through the provision of a more responsive and comprehensive service to its patients.

There is evidence of the positive financial impact Symphony Healthcare Services and the new models of care have on the wider Somerset health system. Analysis is now being undertaken to determine the financial figure for this in 2018/19. In 2017/18, the data indicated that there was:

- £1 million saving from avoided overnight emergency admission growth for SHS practices; and
- There is an actual reduction in the rate of admissions saving £600k.

During 2018/19, Symphony Healthcare Services integrated a further four practices, whilst transferring an existing PMS contract to another provider in Devon. The following practices are therefore part of Symphony Healthcare Services:

Practice	List Size	
Buttercross Health Centre The Ilchester Surgery	4,766 2,627	Contracts Merged
Yeovil Health Centre Oaklands Surgery	6,597 3,978	Contracts Merged
Highbridge Medical Centre	12,654	
Crewkerne Medical Centre West One Surgery	10,960 2,040	Contracts Merged
Wincanton Health Centre	8,826	
Hamdon Medical Centre	5,568	
The Meadows Surgery	3,539	
Martock Surgery Bruton Surgery	10,874 6,132	
TOTAL	**78,561**	

Symphony Healthcare Services has continued to manage and support these practices by adopting the organisation's vision and values as well as introducing the GET strategy. This strategy focussed the mission of the organisation to:

- Grow – increase patient list sizes and practice numbers;
- Enhance – improve the quality and extent of services provided to patients; and
- Transform – transform services to ensure the best use of available resources.

Recent Care Quality Commission inspections of the practices within Symphony Healthcare Services have taken place. The feedback during these inspections has been extremely encouraging and Symphony Healthcare Services will build upon the outcomes to ensure the continuing development of quality services for all patients across all practices.

Symphony Healthcare Services operated at a deficit in 2018/19; however, as referred to above, the entity has led to a reduction in the level of demand across the South Somerset region and a reduction in the number of overnight stays resulting in savings across the acute providers within the county.

Daycase UK LLP: Daycase UK is a subsidiary of Yeovil District Hospital that was formed in June 2016 after an OJEU procurement for a joint venture partner to support efficient day case activity. It is 70 percent owned by Yeovil District Hospital and 30 percent owned by Ambulatory Surgery International (ASI), which is an offshoot of AmSurg a leading US-based day case facility operator. Some 50+ nursing and administrative staff have transferred to Daycase UK. 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.

Daycase UK provides day surgery within the Day Surgery Unit at Yeovil District Hospital and at the Castleton Unit at the Yeatman Hospital in Sherborne across a range of specialties. Daycase UK underwent an announced Care Quality Commission inspection in May 2018, which was followed by an unannounced visit to the hospital in June 2018. The inspection reviewed the five domains of Safe, Effective, Caring, Responsive and Well-led for both locations. The reports following these inspections were published in August 2018 where an overall Good rating was achieved. A number of areas of good practice were highlighted, including a good safety track record, good systems and processes in place to ensure the safe use and maintenance of equipment, adequate nurse staff levels to safely meet the needs to patients, and observation of caring, respectful and compassionate interactions between staff, patients and their relatives.

More recently, a JAG Accreditation visit of Daycase UK outlined that the unit has very good quality, safety, performance and governance structures in place. A number of areas of excellence were highlighted during this inspection although there were some areas for improvement. These areas have been actioned and a repeat review is expected in the coming months.

Yeovil Property Operating Company Ltd: Yeovil District Hospital established a subsidiary company, Yeovil Property Operating Company Ltd, to facilitate integration of GP practices. It enables former GMS practices to sub contract service delivery to SHS whilst retaining the right to receive notional rent from NHSE. The company was incorporated on 19th January 2016. There are no other 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 these are realistic and fundable, as well as identifying opportunities for the Trust to earn income, which can be reinvested into frontline services.

Southwest Pathology Services LLP, SPS Facilities LLP, SW Path Services LLP: Established in 2011/12, Southwest Pathology Services took responsibility for delivering the full range of laboratory services to Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital on 1 June 2012, serving a population of over 500,000 and over 100 GP practices. The SPS hub laboratory provides services for the NHS and other organisations in the southwest, undertaking the high quality, efficient processing of routine and non-urgent testing, reporting results according to clinically agreed turnaround times.

Further information on all group entities can be found within the Trust's Annual Accounts 2018/19. The Trust 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 Group 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 NHS Improvement foundation trust annual reporting manual 2018/19 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 Group has operated with a deficit from 2015/16 and plans to break-even in 2019/20, the Board did consider the principle of going concern and ongoing financing.

The Group has received revenue and capital loans from the Department of Health and Social Care (DOH) enabling the Trust to meet its obligations. The 2019/20 financial plans and cash flow forecasts have been prepared on the assumption that no further loan support will be received from DOH, and existing loans will be renewed as and when they fall due.

As with any Group placing reliance on the Department of Health and Social Care for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of the approval of these financial statements, they have no reason to believe that it will not do so.

Although these factors represent material uncertainties that cast doubt about the Group's ability to continue as a going concern, the Directors, having made appropriate enquiries, have concluded that there is a reasonable expectation the Group 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
	2018/19	2018/19
	£'000	**£'000**
Operating income from continuing operations	153,771	144,546
Operating expenses of continuing operations	(171,852)	(164,177)
Operating loss	**(18,081)**	**(19,631)**
Finance income	40	1,113
Finance expense – unwinding of discount on provisions and financial liabilities	(1,553)	(2,822)
Net finance costs	**(1,513)**	**(1,709)**
Gain/(Loss) on disposal of non-current assets	744	(80)
Share of losses of associate/joint venture	(72)	0
Corporation tax Expense	(109)	0
Deficit for the year	**(19,031)**	**(21,420)**

Revaluation gains and impairment losses – property, plant and equipment	2,956	4,358
Other reserve movements	(15)	0
Total comprehensive income for the year	**(16,090)**	**(17,062)**

Income

	Group	Trust
	2018/19	2018/19
Clinical income	**£'000**	**£'000**
A&E income	6,917	6,917
Elective income	17,825	17,752
High cost drugs Income	10,992	10,992
Non-elective income	35,799	35,799
Other non-protected clinical income	439	439
Other NHS clinical income	38,128	25,919
Outpatient income - Firsts	7,261	7,261
Outpatient income – Follow ups	10,885	10,885
Private patient income	2,464	2,273
AFC pay award central funding	1,273	1,273
Clinical income from activities	**131,983**	**119,510**
Other operating income		
Research and development	896	896
Education and training	4,268	4,268
Receipts of capital grants and donations	728	728
Resources from NHS charities excluding investment income	464	0
Provider Sustainability Fund income	3,374	3,374
Other income	12,048	15,770
Total other operating income	**21,778**	**25,036**
Total operational income	**153,761**	**144,646**

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

Expenditure

	Group	Trust
	2018/19	2018/19
	£'000	**£'000**
Clinical negligence insurance	4,220	4,220
Consultancy costs	374	324
Depreciation and amortisation	4,001	4,140
Drug costs	16,226	15,934
Establishment	3,578	836
Fees for Audit:		
- Statutory audit	59	59
- Audit related assurance services	27	27
- Other assurance	10	10
Internal audit fees	60	60

Tax advisory services	219	67
Impairment	101	1,497
Increase provisions	12	97
Legal fees	232	60
Losses, ex gratia and special payments	17	17
NHS charities expenditure	1,240	0
Premises	8,887	3,842
Purchase of healthcare from non NHS bodies*	5,553	26,025
Rentals under operating leases	623	8
Services from:		
- CCGs and NHS England	20	284
- NHS Foundation Trusts	2,385	3,836
- NHS trusts	277	279
Staff costs:		
- Executive directors'	1,207	915
- Other staff costs	106,737	87,106
- Redundancy costs	510	510
- Non-executive director costs	116	116
Supplies and services (excluding drug costs)		
- Clinical	9,641	4,073
- General	2,947	8,153
Training	484	417
Transport	1,118	1,032
Other	971	233
Total Operational Expenditure	**171,852**	**164,177**

***The Trust figure includes intercompany expenditure with non-NHS wholly owned subsidiaries.

Agency Staffing

Nursing

Over the past year, Yeovil District Hospital has been focussing on filling all of its nursing vacancies to good effect. The Trust is now in the position of having no nursing vacancies within the hospital; one of a small number of trusts in the country to be in this position. 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 further.

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. Our bank fill rates across all staff groups are now consistently above 80% with significant successes in nursing and healthcare assistant bank fill rates.

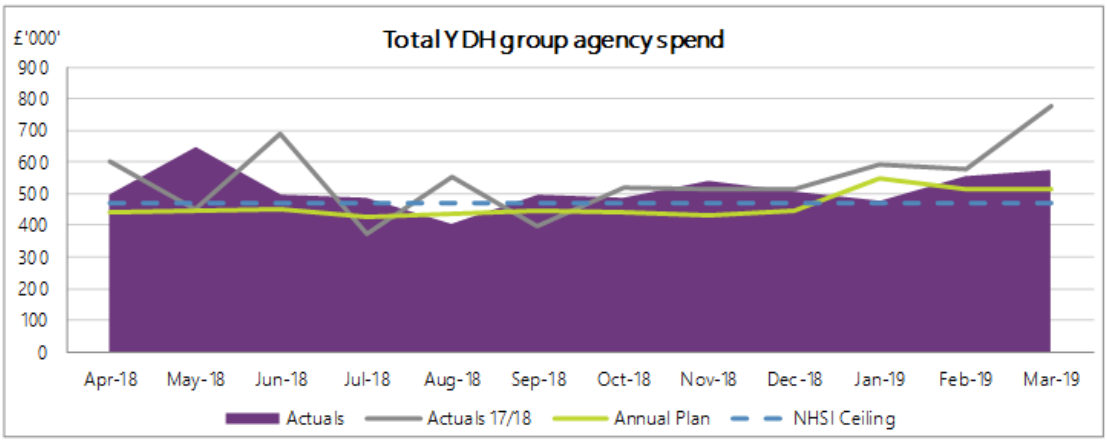
Following recent successes in the Trust’s overseas recruitment campaigns, Yeovil District Hospital now provides nursing recruitment services to 12 other organisations. This includes full support in the advertising, interview, registration, pre-employment document check stages as well as providing training and assessments for the required Objective Structured

Clinical Examinations (OSCE). Going forward, as the Trust's overseas nursing recruitment campaign gathers momentum, the Trust expects to be able to fill the nursing vacancies of the 12 Trusts it is supporting; generating revenue for the hospital and helping other Trusts control their agency spend. The introduction of the new Nursing Associate and Assistant Practitioner roles will also support the nursing staff as this role evolves over the next 12 months.

Medical

Medical staffing is the most challenging area of recruitment with locums continuing to demand high pay rates. However, the Trust's bank continues to grow and it now has 142 medical staff on the Trust's bank. The Trust is undertaking a workforce review during 2019 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 Trust is working hard to replicate the successes it has had with its overseas nursing recruitment campaign.

The agency spend through the year is set out below. The Trust was set an agency ceiling by NHS Improvement of £5.7million for the year. Spend for the year was £554k (9.8%) above this ceiling and £647k 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

£5.1m was invested in capital developments in 2018/19, which included spend on medical equipment, TrakCare (electronic patient record system) development, general site improvements, replacement of the patient meal system, IT upgrades and construction works including the redesign of Frailty Assessment Unit, the Sleep Clinic and Pre-operative Assessment Unit.

Cashflow Statement

	Group	Trust
	2018/19	2018/19
	£'000	**£'000**
Cash flows from operating activities		
Operating deficit	**(18,081)**	**(19,631)**
Non-cash income and expense:		
Depreciation and amortisation	**4,001**	4,140
Net impairments and reversals of impairments	**101**	(1,498)

Income recognised in respect of capital donations	**(728)**	(728)
(Increase)/decrease in receivables and other assets	**314**	6,321
(Increase)/decrease in inventories	**(226)**	(208)
Increase/(decrease) in payables and other liabilities	**(3,049)**	1,723
Increase/(decrease) in provisions	**12**	12
Capital, non-cash transactions and non-operating cash flows	**(665)**	0
Other movements in operating cashflows	**0**	0
Net cash generated from operations	**(18,321)**	(9,869)
Cash flows from investing activities		
Interest received	**20**	1,113
Payments to acquire intangible assets	**(842)**	(592)
Payments to acquire tangible fixed assets	**(2,952)**	(2,463)
Sale of property, plant and equipment	**2,471**	0
Receipt of cash donations to purchase capital assets	**20**	0
Net cash used in investing activities	**(1,283)**	(1,942)
Cash flows from financing activities		
Public Dividend Capital received	**253**	253
Loans received from Department of Health and Social Care	**20,857**	20,857
Movements on other loans	**616**	(6,701)
Interest paid on loans	**(1,332)**	(2,882)
Loans repaid - including finance lease capital	**(155)**	(155)
Interest element of finance lease	**(53)**	(53)
Other capital movements	**(193)**	
Net cash used in financing activities	**19,993**	11,379
Increase / (decrease) in cash and cash equivalents	**389**	(432)
Cash and cash equivalents at 1 April	**4,632**	675
Cash and cash equivalents at 31 March	**5,021**	243

Summary Statement of Financial Position

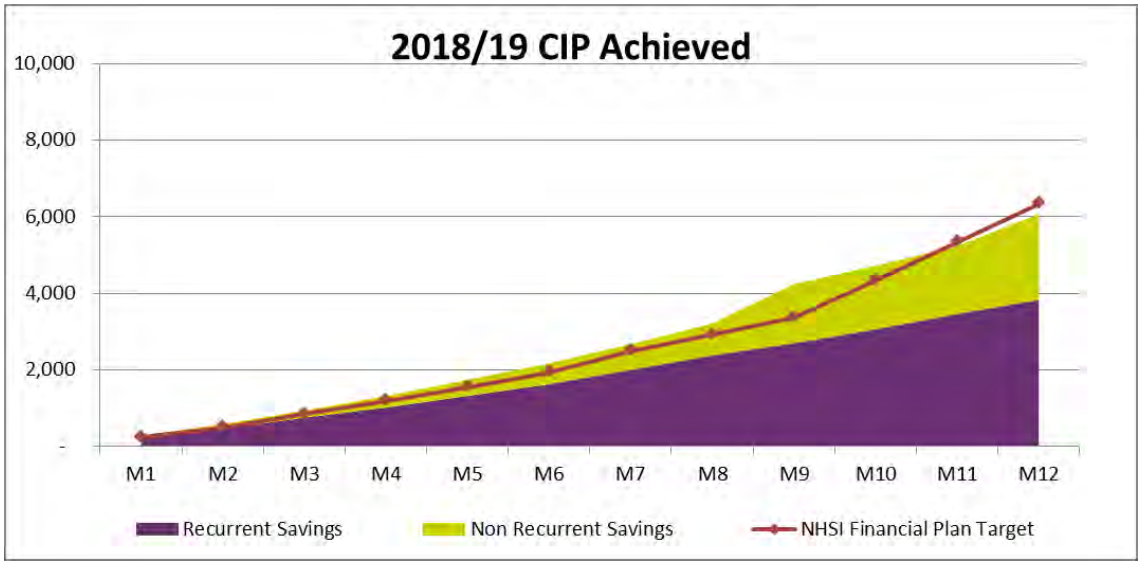
	Group	Trust
	2018/19	2018/19
	£m	**£m**
Non-current assets	66,482	110,966
Current assets	19,873	12,708
Current liabilities	(56,319)	(56,052)
Total assets less current liabilities	**30,036**	**67,611**
Non-current liabilities	(48,479)	(88,219)
Total assets employed	**(18,443)**	**(20,608)**
Total taxpayers equity	**(18,443)**	**(20,608)**

Income Disclosures Statement

Yeovil District Hospital confirms that income from health services is greater than income from any other source. Income that is raised through other sources is reinvested back into the Trust to improve healthcare provision.

Cost Improvement Plans (CIP)

Yeovil District Hospital set a very demanding cost improvement plan target during 2018/19, which was required in order to meet the overall financial control total agreed with NHS Improvement. In year savings of £6,075k were delivered against a target of £6,335k resulting in a shortfall of £260k. 63% of cost improvement plans achieved were recurrent (£3,827k, with the full year effect of recurrent savings being £4,167k). Whilst the target was not achieved, the level of saving continues to be impressive, equating to 4% of turnover.



Environmental Sustainability

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 and Social Care through ERIC returns and Model Hospital Dashboard.

The Trust continues to collaborate 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 Trust has recently started a procurement project to engage with a partner organisation to help deliver its Sustainable Development Management Plan (SDMP).

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

Priorities for 2019/20 are to:

- Develop and implement an SDMP; and
- Take advantage of shared opportunities for sustainability across the STP.

Energy Management

The Trust, through Simply Serve Limited, continues to work with Veolia Ltd on an energy performance contract (EPC) to make guaranteed energy, financial and carbon savings through a number of measures but chiefly through the two Combined Heat and Power (CHP)

systems, rated at 330 and 270KWs, which supply heat and electricity to the Hospital. The EPC continues to deliver savings of over £200K p.a.

Simply Serve Limited procures the Trust's utilities using the Crown Commercial Services (CCS) Framework, ensuring it benefits from CCS's huge buying power. CCS has been proven to deliver significant savings across the NHS estate. In addition, through Simply Serve Limited, the Trust continued to invest in its infrastructure over the past 12 months, implementing a number of energy savings schemes, some of which are set out below:

- Upgrade of Air handling units including installation of new energy efficient motors and controls;
- Replacement of pipe insulation on domestic hot water, heating and chilled water services; and
- Installation of smart controlled low-energy LED lighting

Priorities for 2019/20 are to:

- Investigate and implement water saving projects in conjunction with our partner Aquafund;
- Investigate further opportunities to upgrade lighting to LED low energy units; and
- Create a long-term strategy for the Building Management System, including replacing obsolete controllers and mechanical hardware to reduce energy consumption.

Waste Management

The Trust, through Simply Serve Limited, continues to strive towards its goal of zero waste to landfill by 2020 through an increase in recycling rates, and processing of other waste streams as refuse derived fuel (RDF). The Trust continues to actively reduce waste by ensuring:

- Dry mixed recycling products, including paper, hand towels, cardboard, plastic bottles and metal cans are bulk compacted and sorted into 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 refuse derived fuel;
- Reducing packaging used for hard clinical waste, reducing waste sent for incineration;
- Organic waste from the grounds and gardens is either shredded on-site for mulch or sent for composting and re-use;
- Electronic and electrical equipment waste is sent for recovery and all parts are recycled where possible;
- Removing RVC plastic from the clinical waste stream for recycling; and
- All household batteries are segregated and recycled.

The priorities for 2019/20 are to:

- Further improve waste segregation and awareness; and
- Further roll out of recycling bins to all areas of the Trust.

Jonathan Higman, Chief Executive, 24 May 2019

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

How the Board of Directors and 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. A list of interests of the Board are available within published Board papers.

The general duty of the Board and of each director individually is to act with a view to promoting the success of the Trust 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 that 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 2018/19 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 2018/19, 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 the Chief Executive. 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 addition, the Council of Governors also approved the appointment of the Chief Executive following the recruitment process.

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 2018/19.

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. During 2018/19, 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. This is in line with guidance from the National Audit Office, which states that the total fees for advisory services should not exceed 70% of the total fee for all audit work carried out a public body.

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 and BDO after each meeting and seek views about the executive directors, particularly the Chief Finance and Commercial Officer, as to their effectiveness. KPMG and BDO 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. KPMG 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:

- Management override of controls – valuation of Land and Buildings
- Fraudulent recognition of revenue
- Fraudulent recognition of non-pay expenditure
- Management Override of Controls.

The Audit Committee also considered the Financial Sustainability 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, four elected staff governors, three local authority governors and four other partnership governors. The organisations currently specified as Partnership Organisations that may appoint a partnership governor are NHS Somerset Clinical Commissioning Group (CCG), NHS Dorset CCG and the subsidiary companies of the Trust as one "Partnership Organisation Group", which may appoint up to two members to the Council of Governors.

Members of the public who reside within the Trust's various constituencies can be elected as a public governor. Elected governors (public and staff) are usually appointed for three-year terms. Alison Whitman remains Lead Governor 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 2019, membership of the public constituency saw a small increase compared to the previous year at 7,327. Public membership equates to approximately 4% of the Trust's catchment area. As at 31 March 2019, membership of the staff constituency stood at 2,011.

Continuous internal quality assurance assessments of membership data are undertaken to promote accuracy, remove duplicate records and resolve any other inconsistencies. 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 2019	2,333	1,618	1,763	899	544	170	7,327

Staff Membership

Staff Membership	2018/19
At 31 March 2019	2,011

Elected Governors – Public Constituency

Name	Constituency	Date Elected	Duration of Term of Office (Years)	Attendance at Council of Governor Meetings 18/19
Mary Belcher*	Greater Yeovil	01/06/2016	1	3/3
Michael Beales	Greater Yeovil	01/06/2018	1	3/4
John Webster	Greater Yeovil	01/06/2014 01/06/2017	3 2	4/4
Tony Robinson	South Somerset (South and West)	01/06/2016	3	3/4
Sue Bulley	South Somerset (South and West)	01/09/2014 01/06/2017	3 2	3/4
Michael Clark*	South Somerset (South and West)	01/06/2017	1	2/3
Sue Brown	South Somerset (North and East)	01/06/2015	3	3/4
Janette Cronie	South Somerset (North and East)	01/06/2017	2	2/4
Nigel Stone	South Somerset (North and East)	01/06/2017	2	4/4
Alan Harrison	Dorset	01/06/2018	1	3/4
Bill McDermott*	Dorset	01/06/2018	1	2/3
Virginia Membrey	Mendip	01/06/2017	2	4/4
Alison Whitman	Rest of Somerset and England	01/06/2014 01/06/2017	3 2	4/4

*Michael Clark resigned as a public governor in September 2018. Mary Belcher resigned as public governor in November 2018. Bill McDermott resigned as public governor in February 2019. All 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 18/19
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 2	4/4 1/1
Fiona Rooke	Staff	01/06/2016	2	3/4

*Judith Lindsay-Clark resigned as staff governor in July 2018.

Appointed Governors

Name	Stakeholder Organisation	Attendance at Council of Governor Meetings 18/19
Sekharbabu Thananki	YDH Subsidiary Company "Partnership Organisation Group"	4/4
David Sealey*		0/1
David Recardo	South Somerset District Council	2/4
Rob Childs	Dorset CCG	0/4
Lou Evans	Somerset CCG	4/4
Faye Purbrick	Somerset County Council	4/4
Peter Shorland	Dorset County Council	2/4

*David Sealey resigned as a partnership governor in March 2019.

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 2018/19, 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. Options are also being explored for evening events for further membership and public engagement.

There is a Membership and Communications Working Group of the Council of Governors, which was established to set and evaluate the 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 will also 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 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. As outlined below, 60.1% of NHS invoices and 83.6% of Non-NHS invoices were paid within this target in 2018/19. This is an improved position from 2017/18.

	2018/19		2017/18	
	Number	£'000	Number	£'000
Total NHS trade invoices paid in year	1,490	6,620	1,429	6,226
Total NHS trade invoices paid within target	896	4,021	667	4,401
Percentage of NHS trade invoices paid within target	60.1%	60.7%	46.7%	70.7%
Total Non-NHS trade invoices paid in year	53,175	108,533	51,259	87,699
Total Non-NHS trade invoices paid within target	44,437	97,654	41,075	73,072
Percentage of non-NHS trade invoices paid within target	83.6%	90.0%	80.1%	83.3%

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 are set out in the Quality Account appended to this report.

The Board

The membership, skills and expertise of the Board during 2018/19, together with attendance at meetings, the commitments of the Board members 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.

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.

Board Attendance: 9/9
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 became Chair of the Workforce Committee in March 18.

Board Attendance: 9/9
Board Remuneration Committee Attendance: 5/5

Martyn Scrivens+* — Non-Executive Director

Martyn joined the Trust Board in April 2018.
Martyn is a Fellow of the Institute of Chartered Accountants and chairs the Institute's Internal Audit Advisory Panel. He has 40 years of experience in audit and risk management, operating at Board level with both the public and private sector. Over the last 15 years he has led the internal audit functions first at a major UK bank and then at a global investment and wealth management bank. From 2010 to 2012, he was a board member of the East Kent Hospitals NHS Trust. Martyn chairs the Trust's Financial Resilience and Commercial Committee.

Board Meeting: 8/9
Audit Committee Attendance: 4/5
Board Remuneration Committee Attendance: 4/5

Jane Henderson+*	Deputy Chairperson / Non-Executive Director / Senior Independent Director

Jane Henderson joined the Trust Board in June 2013.
Jane 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 and is the Trust's Senior Independent Director.

Board Attendance: 8/9
Audit Committee Attendance: 5/5
Board Remuneration Committee Attendance: 3/5

Graham Hughes+	Non-Executive Director

Graham Hughes joined the Trust Board in April 2018
Graham has over 40 years of experience in the financial and legal sectors and was previously an Executive Director of Bank and Clients PLC. Prior to this, in his capacity as Managing Partner and latterly Chairman, he developed a legal practice to a multi office large employer. He has a deep understanding of commercial and risk management within the financial sector together with a thorough knowledge of the core strategic principles of heavily regulated and competitive sectors.

He has also been involved in change management, developing policies for large and complex organisations including Whistle blowing, IT Security and Data Protection and People policies. Graham chairs the Trust's Remuneration Committee.

Board Attendance: 9/9
Board Remuneration Committee Attendance: 5/5

Caroline Moore+*	Non-Executive Director

Caroline Moore joined the Trust Board in September 2016.
Caroline 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 and is Managing Director having previously been the Executive Director of Finance, Governance and Risk. She is also a member of the Board of the trading subsidiary Yarlington Homes. Caroline is Chair of the Trust's Audit Committee.

Board Attendance: 7/9
Audit Committee Attendance: 5/5
Board Remuneration Committee: 3/5

Jonathan Higman	Chief Executive

Jonathan Higman joined the Trust Board in January 2009 and became Acting Chief Executive in December 2017. He was appointed as Chief Executive in March 2019. During his time on the Board, 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.

Board Attendance: 9/9

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

Shelagh Meldrum joined the Trust Board in February 2016. Shelagh 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: 8/9

Timothy Newman	Chief Finance & Commercial Officer

Tim Newman joined the Trust Board in February 2013.

Tim was Chief Finance and Commercial Officer and led 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.

Board Attendance: 6/9

Dr Tim Scull	Medical Director

Board Attendance: 9/9

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.

Simon Sethi	Chief Operating Officer

Board Attendance: 4/4

Simon Sethi joined the Trust Board in June 2015.
Simon joined the Trust from Gloucestershire CCG where he was Programme Director for Urgent Care and Deputy Director of Commissioning responsible for commissioning of ambulance and hospital services. Prior to this, he worked in system redesign leading on the creation of the Severn Major Trauma Network and before that in operational management roles in Surgery and Trauma and Orthopaedics at North Bristol NHS Trust. He is a Graduate of the Management Training Scheme. Simon took a sabbatical to learn about other health systems from July to December 2018.

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

Fiona Jones	Interim Director of Operations and Urgent Care

Board Attendance 4/5

Fiona Jones joined the Trust as Interim Director of Operations and Urgent during Simon Sethi's sabbatical.

Fiona joined the Trust from University Hospitals Bristol NHS Foundation Trust where she is a Divisional Director. Fiona has a wealth of experience in leading operational services as well as delivering strategic change.

Tom Norton	Director of Transformation / Chief Information Officer

Board Attendance: 8/9

Tom Norton joined the Trust in September 2017.
Tom has been leading significant change, operational improvement and transformational programmes in a range of industries over the last 15 years. More recently, Tom has turned his attention to healthcare, and for the past 9 years has been leading IT, technology, innovation and transformation functions in health and care, spanning both profit and not for profit organisations.

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 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: 5/9

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. In recent 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 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 Directors' declarations of interest are published within the Board of Directors meeting papers that 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 that 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. This pilot inspection was considered to fulfil the requirements outlined in the well-led framework – consequently a further independent review under the framework will be scheduled in 2020/21. In addition, the Trust was formally

inspected by the Care Quality Commission and NHS Improvement in December 2018 and January 2019 where areas of good practice were identified during both inspections.

In 2018/19, the Trust reviewed and revised its Board governance structure, which included a review through the various working groups, assurance committees and ultimately the Board of Directors. This review included a revised schedule for the Board of Directors that now rotates between strategically and operationally focussed meetings, providing a suitable framework for the review and consideration of strategic developments, both within the hospital, the Somerset STP and the wider healthcare system.

In 2018/19, the Board also undertook a Board and assurance committee self-review survey. The high-level results of this survey were reviewed by the Board in December 2018. It was established that the Board has an appropriate range of performance measures and financial information to enable the Board to monitor operational management performance. The self-review survey highlighted that the Board should potentially dedicate more time to determining emerging issues that could affect the delivery of the Trust's strategy; at present, it was felt that the majority of the Board's time is spent on issues on the day-to-day management responsibilities rather than the strategic direction of the organisation.

Positive aspects of the survey illustrated that the Trust has appropriate sub-committees of the Board in place to support it in carrying out its responsibilities and that the delegation to these sub-committees was appropriate. A review of the Trust's governance and reporting lines will be completed by the Trust's internal auditors as the survey reported that improvements could be made in reference to a potential overlap and duplicate reporting across the Board and the sub-committees.

The Trust has already acted upon a number of the topics raised as part of the self-review survey, including a full overhaul of the Board Assurance Framework and Corporate Risk Register reports. The Board, led by the Company Secretary and Trust Risk Manager, had identified and considered the principal risks to the organisation and the Board's appetite to risks across the seven key risk categories. The revised Board Assurance Framework was implemented and presented to the Board in April 2019.

Further information on internal control, the organisation's performance and 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 32. In 2018/19, the Committee was chaired by Graham Hughes, Non-Executive Director. The Chief Executive and Company Secretary attended the Remuneration Committee during 2018/19 to give advice as required. No other person attended the Remuneration Committee to provide advice or services to the committee. To ensure there are no conflicts of interest concerning items on the meeting agenda, the member of staff to which discussions pertain is not in attendance.

With the exception of the Chief Executive, directors, doctors, and some key functional roles, all staff of Yeovil District Hospital are remunerated in accordance with the NHS National Pay Structure, Agenda for Change. The Chief Executive and all executive directors of Yeovil District Hospital 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 more than £150,000, 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 2018/19, 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. 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 2018/19, following a period where Jonathan Higman held the Acting Chief Executive position, the Trust undertook a formal recruitment process for the Chief Executive. This recruitment process, together with the salary of the position, was reviewed and considered by the Remuneration Committee. The recruitment process was completed in March 2019. In addition, the Remuneration Committee considered the Very Senior Managers pay uplift proposal as provided by NHS Improvement. The position of Chief Finance and Commercial Officer was also reviewed during the year following Tim Newman's resignation.

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 2018/19 was £170,000 to £175,000 (2017/18 £170,000 to £175,000). This was 7.4 times (2017/18 - 6.12 times) the median remuneration of the workforce which was £23,864 (2017/18 - £27,074). The calculation is based on employed members of staff; it does not include locum and agency staff. This difference is largely due to staff turnover.

In 2018/19, the number of employees receiving remuneration in excess of the highest paid director was eight (2017/18 - five). Remuneration ranged from £177,000 to £442,000 in 2018/2019. The employees receiving remuneration in excess of the highest paid director are medical consultants. The highest paid member of staff is a locum consultant who covered the high frequency on-call rota for the relevant service.

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.

Expenses of the Governors and Directors

The Trust has policies on the payment of expenses that governs all staff, including directors, governors and volunteers. During 2018/19, the expenses paid to members of the Board and directors attending the Board totalled £65,571. During the same period, the expenses paid to the members of the Council of Governors totalled £2,325. The combined sum for expenses was £12,570, which compares to £14,576 for 2017/18 and £50,610 for 2016/17. This is following an increase in attendance at system wide meetings for the Somerset Sustainability and Transformation Partnership.

Salary and Pension Entitlements of Senior Managers 2018/19

Name and Title		2018/19					
		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
M Scrivens	Non-Executive Director	10 - 15	0	0	0	0	10 – 15
M Dunster	Non-Executive Director	10 - 15	0	0	0	0	10 – 15
G Hughes	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
J Higman	Chief Executive	150 – 155	0	0	0	185 – 187.5*	335 – 340
T Newman	Chief Finance and Commercial Officer	170 – 175	1,300	0	0	0	170 – 175
S Sethi	Director of Urgent Care and Long Term Conditions	60 – 65	0	0	0	330 – 332.5*	395 – 400
Dr T Scull	Medical Director	165 – 170	0	0	0	0	165 – 170
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	135 - 140	0	0	0	0	135 – 140
K Patrick	Director of Primary Care SHS	30 – 35	0	0	0	30 – 32.5	65 – 70
Dr B Balian	Medical Director SHS	65 – 70	0	0 – 5	0	20 – 22.5	90 – 95
D Stevens	Managing Director SSL	90 – 95	0	0	0	80 – 82.5	175 – 180
R Perkins	Health and Sciences & IT Director SSL	65 – 70	0	0	0	615 – 617.5*	685 – 690
D Shire	Estates and Facilities Director SSL	60 - 65	0	0	0	20 – 22.5	85 - 90

Notes
T Scull's salary includes pay for his clinical and non-clinical responsibilities.
S Sethi took a Sabbatical during 2018/19.
*Pension related benefits is the in-year increase in the overall pension of any given employee. As the pension scheme is a final salary scheme any large increase or decreases to salaries significantly changes the in-year benefits calculation. This amount is not paid by the Trust.

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
T Scull's salary includes pay for his clinical and non-clinical responsibilities.
P Mears - The data above includes a loss of office payment.

Pension Benefits of Senior Managers 2018/19

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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
J Higman	Chief Executive	7.5 - 10	20 – 22.5	45 - 50	110 - 115	592	226	835	22
S Sethi	Director of Urgent Care and Long Term Conditions	15 – 17.5	35 – 37.5	15 - 20	35 - 40	27	211	239	9
D Stevens	Managing Director SSL	2.5 - 5	5 - 7.5	20 - 25	40 - 45	259	104	371	12
R Perkins	Health and Sciences & IT Director SSL	25 – 27.5	80 - 82.5	25 -30	80 - 85	0	620	620	9
D Shire	Estates and Facilities Director SSL	0 – 2.5	0 – 2.5	5 – 10	0 – 5	85	30	118	9
K Patrick	Director of Primary Care SHS	0 – 2.5	0 – 2.5	10 – 15	20 - 25	122	41	166	5
Dr B Balian	Medical Director SHS	0 – 2.5	0 – 2.5	10 - 15	15 - 20	160	26	192	8

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.

No other directors are part of the NHS Pension Scheme hence non-inclusion in the above table.

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
No other directors were part of the NHS Pension Scheme in 2017/18.

Jonathan Higman, Chief Executive, 24 May 2019

Staff Report

The people of Yeovil District Hospital never cease to amaze. They are dedicated in providing the best possible care they can for our patients whilst continually looking for new and innovative ways of doing things; and we are immensely proud of them. The Trust does not take its people for granted and it works hard to engage them in everything it does. Yeovil District Hospital aims to be the best NHS Trust in the country to work for, and it is always looking for new ways to improve people's health and wellbeing.

The Trust Group (including subsidiary companies) employs the following people (as at 31 March 2019):

Headcount (Excluding Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	3	10	13
Non Executives & Chairman	2	4	6
Other Senior Managers	24	9	33
All other employees	2082	571	2653
Grand Total	**2111**	**594**	**2705**

Headcount (Including Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	3	10	13
Non Executives & Chairman	2	4	6
Other Senior Managers	24	9	33
All other employees	2634	743	3377
Grand Total	**2663**	**766**	**3429**

Full-Time Equivalent (Excluding Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	2.22	10	12.22
Non Executives & Chairman	2	4	6
Other Senior Managers	23.25	9	32.25
All other employees	1706.46	541.42	2247.88
Grand Total	**1733.93**	**564.42**	**2298.35**

The average number of employees employed by the Group:

Average Number of Employees (Full-Time Equivalent)	2018/19			2017/18
	Permanent	**Other**	**Total**	**Total**
Medical and dental	154.2	110.4	264.6	255.4
Administration and estates	524.6	36.0	560.6	525.0
Healthcare assistants and other support staff	439.2	14.3	453.4	469.8
Nursing, midwifery and health visiting staff	577.7	43.3	621.0	572.4
Scientific, therapeutic and technical staff	274.0	24.3	298.2	278.9
Total Average Numbers	**1973.9**	**228.2**	**2202.1**	**2101.46**

Staff Costs

Group	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	84,143	78,522
Social security costs	7,771	7,517
Employer's contributions to NHS pensions	9,029	8,707
Agency/contract staff	6,376	6,561
NHS charitable funds staff	0	0
Apprenticeship levy	625	348
Termination benefits	510	553
Total staff costs	108,454	102,208

Absence Data

Figures Converted by DHSC to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
1,987.30	14,218.98	7.15	725,366	23,066

The data provided above is presented as calendar year figures for 2018 and is provided by the Department of Health and Social Care.

The Trust's internal 12 monthly rolling sickness absence rate as of 31 March 2019 for the Yeovil District Hospital group was 3.1%, which meets our target. This compares favourably with the average for the South West which is 4.4%. We have been working hard to support our people and help them stay well. We provide resilience and mindfulness programme and have put in place many health and wellbeing initiatives. Monthly sickness 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 also embeds fairness and inclusion into everything that we do.

Staff Policies and Actions applied during the Financial Year

Yeovil District Hospital has launched the third edition of the Human Resources Manual and published it on the Trust's YCloud (intranet). The polices within the manual are concise, easy to read, colourful, and co-written with trades unions and a Plain English Editor.

The Trust 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. Every effort is made to treat people equally, and provisions are made for reasonable adjustments where required. We also actively encourage people with disabilities to apply for roles within the hospital, 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. The Trust has implemented a system to ensure that all departments are visited in the financial year by the executive and non-executive directors.

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. Bi-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 four YDH staff governors and two subsidiary partnership 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 2018/19 fire, health and safety arrangements and procedures have been strengthened. Replacement and upgrade of fire protection systems have been a major focus, including replacement of fire doors leading from service risers and fire stopping enhancements to maintain smoke free areas in the event of a fire. Fire doors in patient areas have been upgraded to provide additional fire protection levels. Redesign of the Macmillan Department has included extensive upgrading of the building fire protection measures, as has the development of new office space layouts and treatment assessment areas across many levels of the buildings.

Improvements have been made in the way the security, fire and safety team coordinate activities with mutually supporting risk assessment processes identifying and addressing hazards and risks. A Fire Officer role has been made permanent and additional support has been developed around providing manual handling training to support the delivery of training, which has allowed specific focus on the use of patient lifting and movement aids.

The security manager role has been developed to include the responsibilities of the local security management specialist aimed at targeting security risks, especially around security access to buildings, preventing intruders and reducing repeat offenders, which require security intervention. Body worn video cameras have been implemented and are in use extensively with the aim of reducing violence and aggression as well as providing evidence for enforcement action. Lone working applications for raising safety alerts has been introduced aimed at calling for assistance in situations where staff are vulnerable, or at risk.

Conflict resolution training for front line staff has been reviewed and a new programme including assault avoidance and breakaway has been introduced for clinical staff. Risk assessment courses for supervisors and managers have been introduced to enhance and support the requirement to carry out risk assessments.

During 2018/19 there has been a focus on removal of chlorine based chemical products and hazardous substances safety procedures have been developed with practical advice on safe use and storage. A review of safety devices aimed at reducing non-safe sharps has taken place. Contractors' procedures through estates and facilities have been strengthened with contractor induction updates taking place. Additionally a programme of reducing stock levels of medical gas cylinders on wards has been implemented successfully.

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

Yeovil District Hospital complies 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 BDO. 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

Yeovil Hospital recognises the vital importance of staff engagement in enabling it to operate and perform effectively and efficiently. In the 2018 staff survey, Yeovil District Hospital was the best in the region for staff engagement

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 bi-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 are shared on YCloud. Our YCloud-based 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.

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.

At Yeovil District Hospital, an Ethnic Minorities Network has been developed and is run by the members; this network is supported by the executive team. It provides an opportunity for members of staff to discuss experience, share ideas and contribute their collective voices to the organisation's strategic goals. Further staff networks for Carers, Bereavement, Disability/Impairment/Illness and LGBTQ are planned to provide safe spaces for staff with shared interests and characteristics. These again will be run by their members.

Staff Survey

The 2018 Staff Survey results were the best we have ever had. Our response rate was 71%, which was the highest in the country for an acute trust (average was 44%). 91% of scores were also higher than in the previous year.

Key headlines (for an acute trust) are:

- Our 'Health and Wellbeing' score being the best in England
- Our 'Staff Engagement' score was the best in the South West
- Our 'Staff Morale' score was the best in the South West
- Our 'Quality of Care' score was the best in the South West
- Our 'Quality of Management' score was the best in the South West

We have worked hard to engage with our people at every level in the organisation, by ensuring there is regular and open communication, and involvement of people in changes that affect them in a timely way. At the same time, we also recognise the importance of promoting an increased awareness and understanding of hospital activities, and the key issues affecting our performance and service delivery.

We understand the value of two-way communication and we continue to promote and act through existing groups and networks to overcome barriers to effective communication, and

ensure all staff are provided with the opportunity to 'be heard'. Initiatives over the year have included visits by executive and non-executive directors on wards and in departments to find out more about the work of staff and discuss any concerns they may have relating to the service delivered to patients, enabling staff to discuss day-to-day operational issues. We have also increased the use of social media.

Partnership working is taken very seriously by the hospital, and we have an established partnership forum – the Joint Consultation and Negotiation Committee (JCNC) for non-medical staff, and the Local Negotiating Committee (LNC) for medical staff. Both of these committees are the organisation's recognised collective bargaining mechanisms, and all changes that affect staff are discussed at these committees.

Benchmark scores

	2018		2017		2016	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.2	9.1	9.1	9.1	9.3	9.2
Health and wellbeing	6.7	5.9	6.5	6.0	6.3	6.1
Immediate managers	7.2	6.7	7.0	6.7	7.0	6.7
Morale	6.4	6.1	-	-	-	-
Quality of appraisals	5.7	5.4	5.2	5.3	5.1	5.3
Quality of care	7.5	7.4	7.5	7.5	7.4	7.6
Safe environment – bullying and harassment	8.2	7.9	8.4	8.0	8.3	8.0
Safe environment – violence	9.3	9.3	9.4	9.4	9.4	9.4
Safety culture	6.7	6.6	6.6	6.6	6.6	6.6
Staff engagement	7.3	7.0	7.0	7.0	7.0	7.0

Score: 0 = low 10 = high

Future Priorities and Targets

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

We will continue to invest in our people and develop our 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.

A particular focus for this year is to support our people who face violence and aggression from our patients, particularly those with dementia. We have put significant investment into our conflict resolution training, and all our 'frontline' people are required to attend this training.

Trades Union Disclosures

The table below sets out the amount of time our Staff Side Representatives have spent on Trades Unions activities:

	2018/19
Number of Staff Side Representatives	13
Percentage of time spend on facility time	6.99%
Amount spend on facility time: • Total cost of facility time • Total pay bill	 £23,947 £316,289
Percentage of paid facility time spend on trade union activities calculated as (total cost of facility time / total pay bill) x 100	7.57%

Expenditure on Consultancy

£374k – 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

	2018/19	2018/19	2018/19	2017/18
	Compulsory redundancies	Other departures	Total Number	Total number
< £10,000	1	2	3	5
£10,001 - £25,000	0	4	4	4
£25,001 - £50,000	4	2	6	3
£50,001 - £100,000	0	0	0	1
£100,001 - £150,000	2	0	2	1
£150,001 - £200,000	0	0	0	1
Total Number	**7**	**8**	**15**	**15**
Total resource cost			**£511,000**	**£553,000**

The data for 2018/19 includes agreements legally signed and agreed in 2018/19 although due to timing of agreements and payroll, some of these payments will be realised in 2019/20. The level of agreements also reflects the Trust's workforce reduction programme for non-clinical staff.

Other (non-compulsory) departure payments

	2018/19	2018/19	2017/18	2017/18
	Number of Agreements	Value of Agreements	Number of Agreements	Value of Agreements
		£000		£000
Mutually agreed resignations (MARS) contractual costs	8	132	8	132
Contractual payments in lieu of notice	0	0	1	94
Total	**8**	**£132,000**	**9**	**£226,000**

Non-Contractual Departure Payments

There were no non-contractual departure payments made.

Board Members and/or senior officials with significant financial responsibility

	2018/19
	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".	7

Regulatory Ratings

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. Yeovil District Hospital NHS Foundation Trust has been placed in segment 2. This segmentation information is the Trust's position as at March 2019. 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	2018/19 Scores				2017/18 Scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4	4	4
Financial efficiency	I&E margin	4	4	4	4	4	4	4	4
Financial controls	Distance from financial plan	3	1	1	1	4	4	4	2
	Agency spend	2	2	2	2	2	1	1	1
Overall scoring		**3**	**3**	**3**	**3**	**4**	**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.

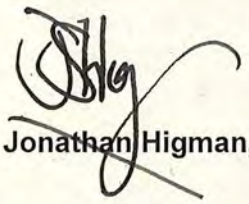
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Yeovil District Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts 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 and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; 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, 24 May 2019

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 2019 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 Deputy Chief Executive/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 Trust Risk Manager within the Clinical Governance Department together with a Maternity Risk Manager. In addition, the Boards of the group's subsidiary companies are responsible for reviewing the risks associated with that entity although the Yeovil District Hospital is ultimately responsible for risk management.

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. The Hospital Management Team meetings, chaired by the Chief Executive, review the corporate risk register on a quarterly basis. The meeting will undertake a deep dive review of areas of risk highlighted during the course of these reviews.

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 are provided by the Trust 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.

In 2018/19, Yeovil District Hospital undertook a comprehensive review of the risk register and board assurance framework (BAF) to improve the monitoring processes and provide additional assurance on any mitigating actions. The BAF includes details of the principal risks that may affect the Trust achieving its objectives or core aims, how they are currently controlled and what sources of assurance the Board have that the risks are being addressed and managed appropriately. It also details action to address the risks to reduce the risk rating to the target level and to meet the risk appetite set.

The wider piece of work to review the risk register included the implementation of a new risk management system in quarter four of 2018/19, which has improved the oversight of all departmental and organisation wide risks. The Board have considered and are due to finalise the Trust's risk appetite in June 2019 against the following risk categories: quality and governance; compliance and performance; continuity of service; operational risk; financial risk; business risk; and reputation risk. The newly revised reports were implemented in April 2019 and will be reviewed on a quarterly basis by the Board assurance committees and the Board of Directors. All papers considered by the Board of Directors include a cover sheet, which outlines the links to the BAF, and the risks which the paper is aimed to address.

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 Trust 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 Improvement Board whilst complaints are reviewed through the Patient Experience Committee and Improvement Board. 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 Ulysses Safeguard risk 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 updates from the Patient Experience Department on a quarterly basis with the Board receiving a high-level update on the learning from complaints and incidents 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 2018/19 to include the Maternity Risk Management Strategy. This strategy is undergoing further revision following the review and reformatting of the risk register and BAF. The Trust's Risk Management Strategy applies to the hospital as well as Simply Serve Limited, Daycase UK and Symphony Healthcare Services. All risks across these entities are managed through the newly implemented Ulysses Risk Management System.

The Risk Management 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 revised Trust risk appetite has been considered by the Board in quarter four against the seven key risk categories and is due to be finalised in June 2019. This appetite 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 2019-2021 is aimed at achieving excellence in clinical care. The Quality Report for 2018/19 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 that are presented to the Board at a seminar session.

Yeovil District Hospital utilises the national reporting and learning system (NRLS) for the reporting of all patient safety 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 areas 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 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 Trust is fully compliant with the registration requirements of the Care Quality Commission.

A comprehensive CQC inspection took place in December 2018 and January 2019. A comprehensive action plan has been developed as a result of the inspection and the final report. Progress against this action plan will be reviewed and monitored by the Board of Directors and the Governance and Quality Assurance Committee.

It has been a challenging year for the NHS with continuing unprecedented levels of demand that 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 was one of a small number of trusts that 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 2019/20, including:

- Cuts in Somerset County Council budgets resulting in increased demand on Trust services, extended patient lengths of stay and additional unplanned costs;
- Risk of in year deficit being higher than budgeted which leaves a funding shortfall;
- Insufficient inpatient capacity and Child and Adolescent Mental Health Services support for children requiring acute admission to paediatrics;
- Risk of not being able to progress evacuation in the event of fire resulting with potential exposure to products of combustion; and
- The fire compartmentation in Main Theatres not of a sufficient standard to support, defend in place and aid progressive horizontal evacuation in the event of fire and smoke internal to Theatres.

There are a number of mitigating actions and processes in place to reduce these risks, including theatre compartmentalisation barrier work commencing in February 2019 and currently ongoing. This work is planned across three phases resulting in a reduced risk rating. In addition, fire evacuation exercises are carried out to maintain staff skills and competence.

Due to the increasing demand for acute services, in order to maintain 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 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 Home First service with the aim of getting patients home. The creation of new models of care and services such as the Trust's Frailty Assessment Unit 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.

During 2018/19, 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;
- Investment in clinical leadership to recognise deteriorating patients;
- Increasing junior medical cover and out of hours support services;
- Increasing midwifery staffing levels;
- Strengthening arrangements for End of Life Care;
- Focusing on infection prevention and control; and
- Strengthening arrangements for the Freedom to Speak Up Guardian and Guardian of Safe Working.

In order to ensure compliance with the Developing Workforce Safeguards guidance, the Trust has developed a number of monitoring dashboards to support the Trust in making informed, safe and sustainable workforce decisions. These dashboards review various key performance indicators to ensure that the right staff with the right skills are in the right place at the right time. The dashboards highlight patients' needs, acuity, dependency and risks and are utilised alongside professional judgement to ensure that workforce decisions promote patient safety and compliance with the Care Quality Commission's fundamental standards and the Board's statutory duties.

The Trust is working to enhance the management of its staff and become class leading at identifying, harnessing and retaining people with the skills and potential to achieve the organisational vision. As an organisation, Yeovil District Hospital is undertaking a thorough workforce review of all clinical roles and are developing plans for every clinical area to help identify the potential gaps and savings in the workforce over the coming years. This is being rolled out across YDH during 2019/20.

The approach of YDH to workforce planning is to:

- Understand the national context;
- Understand the regional context;
- Understand STP strategies;
- Identify our top five local risks;
- Identify our top five local opportunities;
- Understand service budgets;
- Identify proposed changes to the workforce in the next two years;
- Identify proposed changes to the workforce in the next three to five years; and
- Understand the financial impact of the proposed changes.

The six monthly Safer Staffing Report complements this process. This report highlights any significant changes in nursing and midwifery workforce; provides the Board with an overview of key issues and makes clear recommendations for any changes to the nursing and midwifery establishment.

The Trust, via the Governance and Quality Assurance Committee, reviewed the areas of focus for quality improvement and the updated Quality Improvement Strategy in 2019. This strategy incorporates national recommendations, including safe staffing, considers system wide challenges, STP ambitions 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. Improving access to high quality end of life care remains a priority.

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. This has included 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. A number of key deliverables for the Somerset system have been identified, including:

- Improving access to elective care in the west of the county and move towards more equitable access of services across the county. The agreed ambition is for the elimination of over 52-week waiters and ensuring performance equalisation.
- Investing in core mental health services, recognising the current level of investment and service gaps, and implementing universal support services for children and adults aimed at mitigating specialist demand.
- Implementing neighbourhoods across the system to work to support the longer-term mitigation of demand growth. Inclusive of the setup of primary care networks, the system will review the scope and range of community services. This will be a prevention focussed approach to mitigate and reduce escalation. These plans recognise the potential need to move away from a (excess) reliance on bed-based care.

- Implementing and developing acute service changes, implementing agreed changes to acute pathways and developing and agreeing proposals for longer-term changes to elective referral patterns with the aim to improve waiting times.

Principles of Corporate Governance

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.

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. These encourage Boards to conduct a formal evaluation of their own performance and that of its committees and directors. Accordingly, Yeovil District Hospital had developed an action plan resulting from a well-led survey in conjunction with KPMG in 2017/18. This survey reviewed the Board's self-awareness and considered its performance. In addition and as referred to on page 38, in December 2018, the Trust undertook a full Board and Committee self-review that considered the strategic foresight and culture, Board operation, Board performance, operation of the Board sub-committees, corporate governance and professional development and support of the organisation. The high-level results of this assessment were considered by the Board.

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 executive monthly developmental away days. A clear Board Governance Structure is in place that outlines the reporting lines from ward to Board (see diagram below). This structure includes a number of Board Assurance Committees.

The Workforce Committee advises the Board on the strategic, transformational workforce agenda and reviews the 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 committee scrutinises workforce data and plans across the entire Yeovil District Hospital Group. In 2018/19, the committee met ten times within the year although this is to be reduced to a bi-monthly basis in 2019/20.

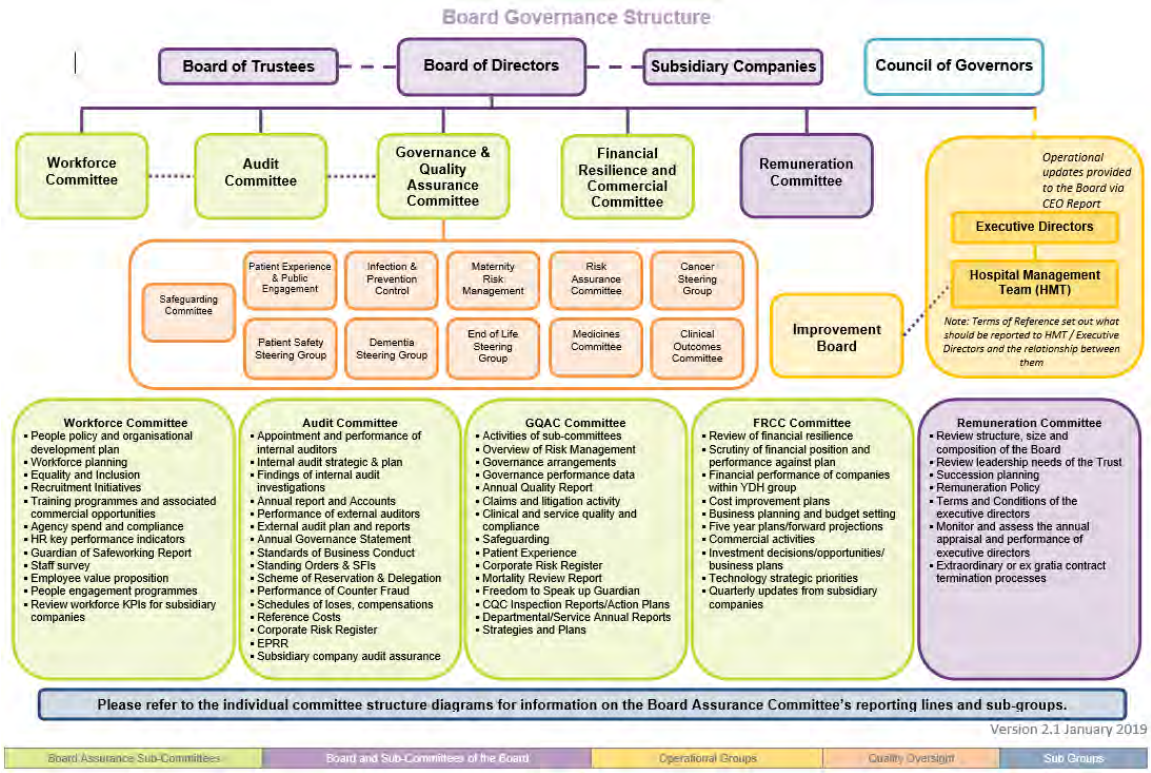
The Governance and Quality Assurance Committee has a wide remit to review a number of topics, including clinical and service quality and compliance, safeguarding, patient experience, learning from deaths, Freedom to Speak Up updates, departmental annual reports, Quality Improvement Strategy, Annual Quality Report and claims and litigation activity. It meets on a quarterly basis.

The Audit Committee receives the findings from across the Trust group of internal audit investigations, reviews the internal audit strategy and plan, annual accounts and reports, standards of business conduct, counter fraud, emergency preparedness, resilience and response and health and safety. It meets on a quarterly basis.

The Financial Resilience and Commercial Committee meets on a monthly basis. It supports the Board by reviewing financial resilience of the organisation, scrutinises the financial position and performance against the financial plan, the financial performance of the wider Yeovil District Hospital group, progress against cost improvement plans, business planning

and budget setting, commercial activities and considers investment decisions, opportunities and business plans.

The current Board Governance Structure for 2018/19 is shown below:



Individual Board meetings also take place across the three entities, Simply Serve Limited, Daycase UK and Symphony Healthcare Services. These Board meetings review the strategic and commercial direction of the organisation together with various key performance indicators across various categories, including performance, activity levels and workforce. These entities report directly to the Trust Board of Directors Part 2 meetings on a quarterly basis with a highlight report outlining recent developments, activity, financial performance and strategic direction. In addition, the entities report to the Financial Resilience and Commercial Committee on their financial and commercial performance. The Trust's workforce committee also scrutinises the workforce data of the Yeovil District Hospital group.

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 2018/19, 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.

The Trust has a Code of Conduct and Conflicts of Interest Policy in line with the national 'Managing Conflicts of Interest in the NHS' guidance provided by NHS England in 2017. In

line with this policy and guidance, the Trust seeks declarations from all members of staff identified as a “decision maker”. The interests of the Board of Directors are published within each set of Board meeting papers and are available on the public website. A review of the Trust’s policy and procedures will be completed in the first half of 2019/20 with publication of all “decision maker” interests expected following this review. Additional procedures are in place to ensure that conflicts of interests are suitably managed or avoided during all procurement and tender processes.

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’s 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). This includes assurance of the Trust’s state of readiness to respond to the challenges, threats, hazards and major disruptive events that may impact on the delivery of its services, or require a wider community response.

In September 2018, through internal and external assurance. Yeovil District Hospital was declared ‘Substantially Compliant’ and continues to maintain a high level of preparedness. The previous year’s assurance report found that the Trust had five standards partially compliant, three of which have been completed and now observed as Fully Compliant. The remaining outstanding standards relate to business continuity; these are a key area of focus for the Trust.

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

The NHS continues to experience a challenging economic environment, namely as a direct result of the continuing unprecedented levels of demand on health and social care, a higher proportion of residents aged over 65 in South Somerset than the rest of England, difficulties in the recruitment of substantive staff and an increasing complexity of patient conditions.

Due to the deficit financial position for Yeovil District Hospital and the wider Somerset system a drivers of the deficit report was commissioned from NHS Improvement. This report outlined that the drivers of the deficit within the Somerset system were split between the following categories: structural, strategic and operational. Operational reasons were deemed to be in the control of a single organisation, such as inefficiency in cost improvement plans. Strategic reasons were recognised to be outside of the control of one organisation and structural reasons were recognised to be outside of the control of the entire system. The drivers of the deficit report highlighted that the scale of the challenge in both

the structural and strategic categories meant that just focussing on improving operational efficiency would not close the financial gap for the Somerset system. Even with this, Yeovil District Hospital continues to identify and realise significant cost improvement plans that hold a high recurrent savings rate. In addition, Yeovil District Hospital is working collaboratively with the Somerset STP to develop a long-term plan to return the system to a financial balance position. The Trust is fully engaged with the Somerset Fit for my Future Programme.

The Trust had a Use of Resources inspection completed by NHS Improvement in January 2019; the report was published in May 2019. The Trust was rated Inadequate for using its resources productively. NHS Improvement rated the Trust as Inadequate as "the trust had the twelfth highest overall cost per Weighted Activity Unit (WAU) nationally and had a deteriorating deficit position representing 15.1% of its turnover, the fourteen highest nationally." There were however a number of areas where the inspection identified several outstanding practice areas, including the Trust having a very low rate of delayed transfers of care achieved through the Home First initiative and weekly multi-disciplinary team meetings; successes in the recruitment of overseas nursing and a low rate of turnover for these nurses. The Trust also provides support to a number of organisations across the region on nursing recruitment. The inspection also acknowledged the zero percent nursing vacancy rate at the time of the inspection following the successful recruitment campaigns. The Trust's procurement function was also recognised as ranking 11 out of 136 on the procurement league table.

There were however, a number of areas for improvement and as a result, a number of cost control measures have been implemented at Yeovil District Hospital. This builds upon a review of the approach to financial improvement and cost improvement plans undertaken by PricewaterhouseCoopers (PwC). These various cost control measures had been considered by the Board of Directors and led to the implementation of further processes and actions.

To support this process, the Trust has brought together teams across the organisation whose key role is to support and deliver improvements and transformation with a key priority to deliver the Trust wide Efficiency Programme across all business units and the cross cutting programmes which will be running at Trust level. Progress is to be monitored through a Project Tracker and Project Dashboard and will be used to inform priorities, allocation of resource and identify resource capacity limits.

In addition, the Trust held an "Efficiency Day" at the end of March 2019. This led to the development of 36 efficiency projects with a focus on improving outcomes for patients, better management of healthcare for the local population and ensuring financial sustainability. The projects cover a wide range of services, including, amongst others:

- Outpatient redesign (reducing unnecessary appointments, paper-light approach, reductions in the waiting list length);
- Bed utilisation (implementing further productivity gains within elective surgery, reducing escalation expenditure, implementing new models of care);
- Theatre productivity (increasing capacity and theatre utilisation; review and implementation of the recommendations from the Getting it Right First Time initiative);
- Workforce re-design (reducing agency spend reduction across both nursing and support services, reducing the agency spend and usage of medical staff, ensuring the right workforce is in place to support new models of care);
- Digital and technology (ensuring there is adequate support to develop and implement Efficiency Projects, various digital improvement projects to assist in streamlining processes);

- Corporate review (ensuring reductions in inefficient processes, exploration of shared back office functions across the Somerset region);
- Medicines management (structured reviewed by clinical area, review of spend and procurement processes);
- Symphony Healthcare Services (delivery of SHS transformation programme); and
- Simply Serve Limited (delivery of SSL efficiency programme).

Each programme has an executive owner or responsible person, a clinical lead and transformation lead with weekly reporting to the executive Directors meetings, the Financial Resilience and Commercial Committee and ultimately the Board of Directors.

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 meetings of the Board in addition to the full operational and financial reports. The Trust Board schedule rotates between operational and strategic focussed meetings with an in-depth review of performance on a quarterly basis. Operational management and the co-ordination of services are delivered by the strategic business units. Performance is also reviewed monthly 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.

As a result of the financial position, the external auditors provided a qualified opinion for 2018/19.

Information Governance

In March 2018 NHS Digital released the Data Security & Protection Toolkit (DS&PT) replacing the Information Governance Toolkit (IGT), lending itself to a more digital world and addressing standards laid down by the National Data Guardian's (NDG) review published in 2016.

The Trust submitted a baseline assessment in October 2018 with a final submission in March 2019 for the year 2018/19. The Trust published with a 'Standards not met' assessment. An improvement plan setting out the steps which will be taken to meet the toolkit standard within the first six months of 2019/20 was developed and submitted to NHS Digital for review. The Trust has received confirmation from NHS Digital they agree with the Trust's improvement plan and the Trust's assessment has been changed to 'Standards not fully met (Plan Agreed)'.

On 25 May 2018 General Data Protection Regulations (GDPR) were released. With guidance from the Information Commissioners Office (ICO), the Trust has undertaken the following work:

- Reviewed and updated our Information Governance training;
- Reviewed all contracts to establish the lawful basis for processing personal information;
- Updated our Privacy Notices for patients, staff and members of the Trust,
- Appointed a Data Protection Officer;
- Ensured Subject Access Requests are responded to within 1 month with no charges made;
- Reporting incidents via the DS&PT matrix within 72 hours and following further investigation processes where required;
- Implemented a Data Protection Impact Assessment (DPIA) Policy to support the review of new processes and technologies;
- Created a database to record any data subjects exercising the right to stop processing their data; and
- Reviewed working practices to ensure lawful international transfers.

The Trust continues with this 'work in progress' to ensure it meets GDPR/DPA standards and compliance. The Trust has developed an Information Governance Workplan, which encompasses both the GDPR/DPA standards and the DS&PT improvement plan.

In line with the DS&PT reporting tool, six incidents were reported to the ICO in 2018/19. Five of those incidents related to information being disclosed in error with the remaining incident relating to unlawful obtaining of personal data. The incidents were fully investigated, with action plans created where appropriate and additional targeted IG training sessions made available. The ICO were notified of all six incidents and have investigated these. The ICO decided in six of the incidents that no further action by the ICO was necessary but made recommendations for the Trust to take forward in four of the incidents. The ICO advised the Trust that for one of the incidents reported to them, they did not feel it was a reportable data breach under Article 33 of the GDPR.

Data security and information governance breaches are reported and monitored through the Information Governance Steering Group, which reports to the Audit Committee.

The Senior Information Risk Owner for 2018/19 was 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 with an in-depth review of this information taking place on a quarterly basis. In addition, the information is 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 Steering Group, Patient Experience and Engagement Steering Group 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 Clinical Governance Team.
- Compliance with NICE guidance is measured and monitored through the Strategic 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.
- 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

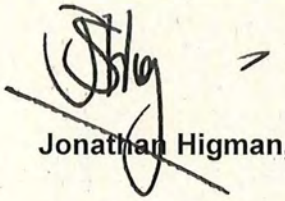
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within Yeovil 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 Governance and Quality Assurance Committee also reviews the Risk Assurance Committee work plan and governance framework in respect of their assigned risk review areas, reporting directly to the Board.

The 2018/19 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, 24 May 2019

Yeovil District Hospital NHS Foundation Trust

Quality Account

2018/19

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Part Three: Other Information

Annexes:

Our Commitment to Quality

Statement from the Chief Executive

Welcome to Yeovil District Hospital ('YDH') NHS Foundation Trust's Annual Quality Account for 2018/19.

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: 47,307 people were admitted to our hospital, and 55,715 people attended our emergency department (A&E). More than 65,762 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.

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.

The results of the 2018 Staff Survey show that the Trust continues to improve and we are above average in virtually every area. Our response rate was 71%, which is the highest of any acute trust in the country. The average was 44%.

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 2018/19, 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 **C**ommunication
A positive *A*ttitude
R **R**espect for patients, carers and staff
E **E**nvironment 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.

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 Improvement Strategy and Safety Improvement Plan.

These objectives align with our Quality Improvement Strategy and will be measured by a defined list of indicators. The quality priorities are derived from reviews of national reports, local issues and challenges, patient feedback and public engagement events. Indicators include:

- Learning from deaths
- Hospital Standardised Mortality Ratio (HSMR)
- Summary Hospital-level Mortality Indicator (SHMI)
- Serious incidents (SI's) including maternity safety
- Patient and staff feedback - Complaints and PALs
- Health Care Associated Infections (HCAI)
- Performance against Commissioning for Quality and Innovation (CQUIN)

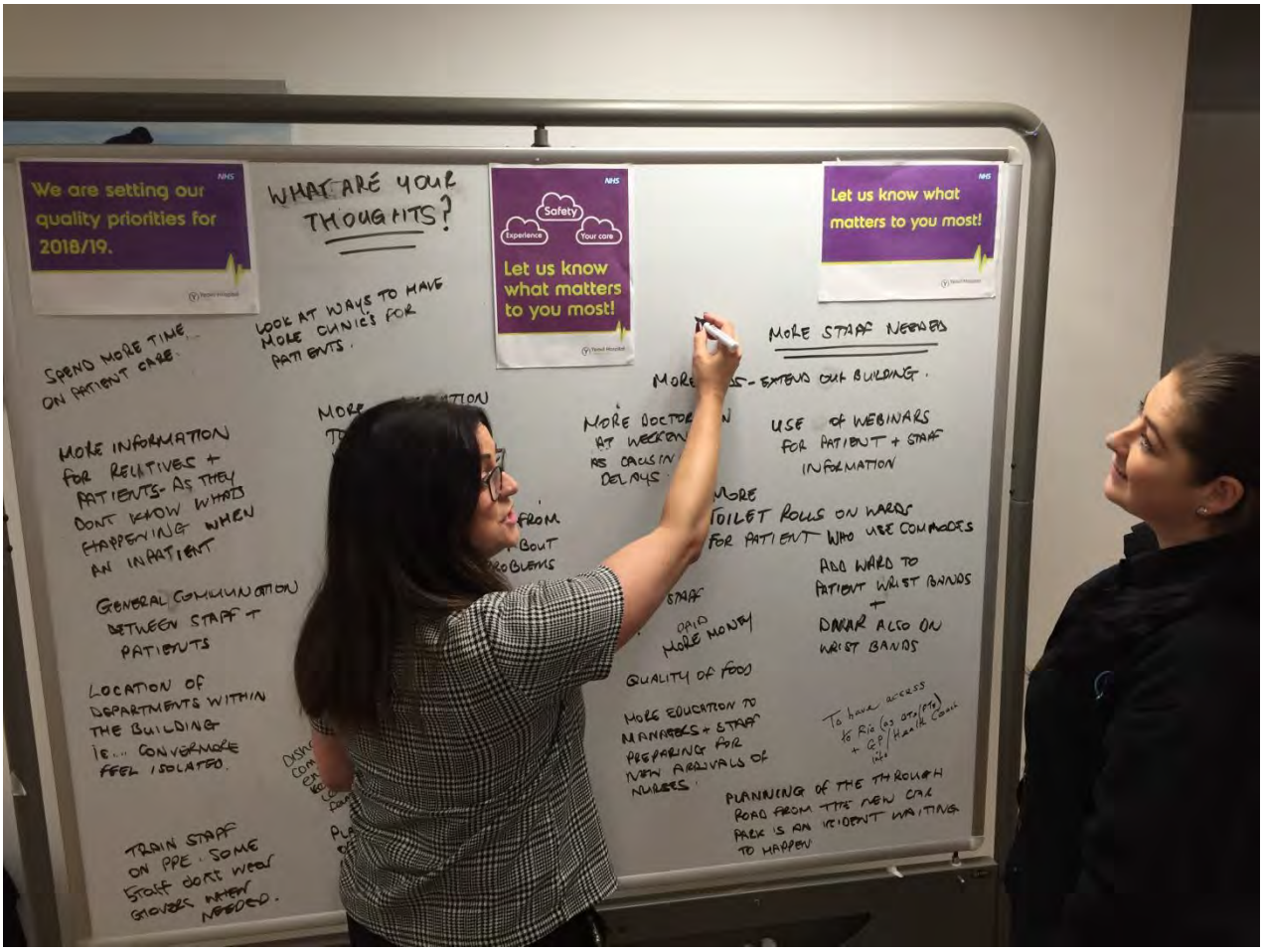
Performance against these, as well as our focus for 2019/20 are outlined in this report.

2. Priorities for Improvement and Statements of Assurance from the Board

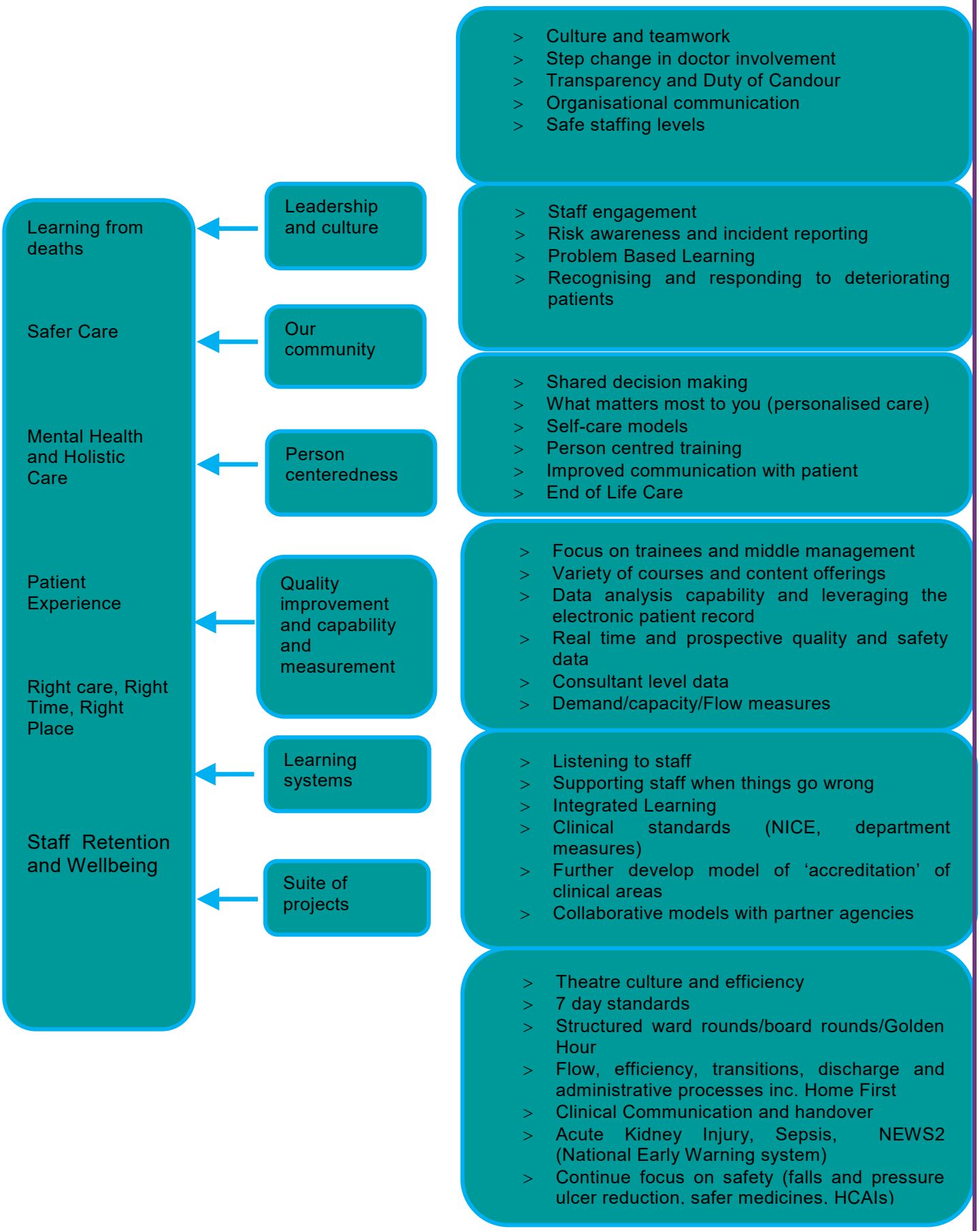
2.1 Quality Improvement Priorities

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 2019/20 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, and a countywide 'Always Event' where the emphasis is on patient and public participation to design service improvements and ensure elements that are most important to the patient are always included.



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. 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. A driver diagram is a visual display of a team's theory of what "drives," or contributes to, the achievement of a project aim.


Learning from deaths
Safer Care
Mental Health and Holistic Care
Patient Experience
Right care, Right Time, Right Place
Staff Retention and Wellbeing
Leadership and culture
Our community
Person centeredness
Quality improvement and capability and measurement
Learning systems
Suite of projects
> Culture and teamwork
> Step change in doctor involvement
> Transparency and Duty of Candour
> Organisational communication
> Safe staffing levels
> Staff engagement
> Risk awareness and incident reporting
> Problem Based Learning
> Recognising and responding to deteriorating patients
> Shared decision making
> What matters most to you (personalised care)
> Self-care models
> Person centred training
> Improved communication with patient
> End of Life Care
> Focus on trainees and middle management
> Variety of courses and content offerings
> Data analysis capability and leveraging the electronic patient record
> Real time and prospective quality and safety data
> Consultant level data
> Demand/capacity/Flow measures
> Listening to staff
> Supporting staff when things go wrong
> Integrated Learning
> Clinical standards (NICE, department measures)
> Further develop model of 'accreditation' of clinical areas
> Collaborative models with partner agencies
> Theatre culture and efficiency
> 7 day standards
> Structured ward rounds/board rounds/Golden Hour
> Flow, efficiency, transitions, discharge and administrative processes inc. Home First
> Clinical Communication and handover
> Acute Kidney Injury, Sepsis, NEWS2 (National Early Warning system)
> Continue focus on safety (falls and pressure ulcer reduction, safer medicines, HCAIs)

Priorities and Summary of Performance to Date

2018/19	Year-end Achievement
Priority 1	
Learning from deaths Embed processes where investigation and learning occurs if care concerns have been identified and where these may have led to an adverse outcome for the patient (measured by HSMR, SHMI, SI's, National Audit of Care of the Dying, Mortality and LeDeR reviews).	Our Summary Hospital-level Mortality Indicator (SHMI) has remained within the expected range compared with other Trusts at 0.9624 (as at September 2018). Our Hospital Standardised Mortality Ratio (HSMR) is lower than expected rage at 88.6 The Copeland Risk Adjusted Barometer (CRAB) observed/expected ratio for deaths following surgery has remained below the normal ratio of 1.0. We have placed greater emphasis on the actions to address learning from mortality reviews and have implemented the following: • Somerset Treatment Escalation Plan (including resuscitation orders) • Advanced Communication Training for senior staff • New End of Life Care Plan • New Endoscopic Retrograde Cholangiopancreatography (ERCP) care pathway to improve post-operative care • LeDeR (Learning Disabilities Mortality Review) reviews are completed and learning from county wide steering group is shared at the mortality review group and Clinical Outcomes Committee
Priority 2	
Safer Care Continuous reduction in avoidable harm (measured by incidence of pressure ulcers, falls, medication incidents, maternity safety metrics, implementation of NEWS2, compliance with sepsis CQUIN, SI's and Never Events, safe staffing).	The Trust reported 63 pressure ulcers (grade 2 and above) in 2018/19 compared with 60 in 17/18. However, this year NHS Improvement (NHSI) instigated recommendations to standardise and streamline definitions of pressure ulcers nationally. Previously a 72hr rule from admission was nationally agreed in terms of defining a community acquired pressure ulcer and thereafter defined as healthcare associated pressure ulcer. The new guidance defines that if the pressure ulcer is not identified on admission then it is healthcare associated irrespective of whether these were identified within 72 hours of admission. This change would reflect the minimal increase in numbers. There continues to be a drive trustwide and within the county through collaborative working to standardise best practice, with a focus around the risk assessment and the implementation of preventative measures in terms of reducing the risk of patients acquiring pressure ulcers. There were 762 inpatient falls compared with 813 in the previous year. 0.5% resulted in moderate or severe harm demonstrating a decrease of

	0.83%. The rate per 1,000 bed days for 2018/19 was 6.83 which compares to 7.01 for 2017/18. A total of 692 medication incidents were reported in comparison with 729 for the same period in 17/18. We commenced implementation of electronic recording of NEWS2 (National Early Warning Score) and actively participated in the National Patient Safety Collaborative focusing on systems to improve recognition and management of deteriorating patients. No Never Events were reported in 2018/19.
Priority 3	
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, number of Mental Health First Aiders, establishment of Psychiatric Liaison Pathways).	We trained 32 staff to be Mental Health First Aiders to facilitate early recognition and signposting for staff in need of support. The Trust achieved a 53% reduction in emergency attendances of the cohort of high impact users identified for the Commissioning for Quality and Innovation (CQUIN) 18/19. We have worked collaboratively with Somerset Partnership NHS Foundation Trust Psychiatric Liaison Team to ensure early assessment and treatment of those in crisis and requiring specialist support. This includes improvements in policy and practice. There has been an extension to Child and Adolescent Mental Health Services (CAMHS) to improve access over a wider working day and we have appointed a dedicated CAMHS Complex Care Practitioner to improve care co-ordination between acute paediatric services and CAMHS. 300 staff have received training in conflict resolution during the year.
Priority 4	
Patient Experience Improve patient experience using co-design, personalised care planning and family centred care to inform service improvements and care pathways (measured by adoption of Always Events methodology, complaints, PALS concerns, public engagement events and user engagement in identified work streams).	We collaborated with partners to host the first Always Event to be held as a system and focused on improving the experience of discharge. More than half the 50 attendees were patients and users of services. The event has resulted in a number of initiatives to ensure discharge is a more patient-centered process. The KO41 health and social care data return reported 89 complaint investigation cases throughout 2017/18 and 65 for 2018/19. We have noted a continued reduction in formal complaints in favour of a more timely response to concerns reported to PALS.
Priority 5	
Right Care, Right Time, Right Place	We continue to participate in all relevant

Strengthen collaborative working across the health and social care system to deliver sustainable improvements in care and in line with the Somerset Clinical Strategy, Fit for My Future (measured by involvement and progress with seven day services compliance, improving discharge, Somerset Sustainability and Transformation Partnership (STP) Programme Boards and work streams, Somerset QI Faculty and Somerset Academy programmes of work).	Somerset Sustainability and Transformation Partnership (STP) programmes of work and have been instrumental in shaping future cohorts of the Somerset Academy. We achieved compliance with the four priority standards for seven day services and are focused on improving delivery of consultant and daily reviews at weekends. We secured Academic Health Science Network funding to lead the use of NEWS2 and Situation, Background, Assessment, Recommendation (SBAR) across the acute General Practice (GP) referral pathway for patients requiring admission from care home. We have led the testing and implementation of Clinical Commissioning Group (CCG) Ultrasound Guidance to improve the quality of requests across the system and reduce unwarranted variation.
Priority 6	
Staff Retention and Wellbeing Develop a robust approach to staff retention across all staff groups with a focus on celebrating excellence in practice, promotion of wellbeing support and activities, opportunities for development and career progression within Somerset and across providers (measured by recruitment and retention metrics, staff survey results, delivery of workforce strategies and plans).	We were the top organisation in the National Staff Survey for staff reported wellbeing and achieved a reduction of 3.3% in Registered Nurse turnover. We were second nationally in the NHS Leadership survey by the National Centre for Diversity. We successfully recruited Registered Nurses from overseas to report 0 wte vacancies at year-end. We continue to recruit for 11 other NHS organisations in line with the national workforce strategy.

Priorities for 2019/20

In reviewing our priorities and progress against 2018/19 plans, we have considered where further improvement is required and engaged with patients, families and staff to identify areas for particular focus. We continue to focus on the following priorities and have aligned these with those identified by the Taunton and Somerset and Somerset Partnership NHS Trusts Alliance.

Priority 1	**Learning from Deaths** Embed processes where investigation and learning occurs if care concerns have been identified and where these may have led to an adverse outcome for the patient (measured by HSMR, SHMI, SI's, National Audit of Care of the Dying, Mortality and LeDeR reviews).
Priority 2	**Safer Care** Continuous reduction in avoidable harm (measured by incidence of pressure ulcers, falls, medication incidents, maternity safety metrics, implementation of NEWS2, compliance with the Falls, Flu vaccination and Antimicrobial Reduction Commissioning for Quality and Innovation (CQUINs) and incidence of Healthcare Associated and Gram-negative bloodstream infections, SI's and Never Events, safe staffing).
Priority 3	**Mental Health and Holistic Care** Increase staff capability to recognise and respond to those with mental health needs (children, adults in crisis, older people), ensuring parity of esteem whilst reducing the incidence of violence and aggression against staff (measured by -

	Conflict resolution training, CAMHS related incidents, numbers of incidents of violence and aggression, patient experience of those receiving mental health services whilst in an acute setting).
Priority 4	**Patient Experience** Improve patient experience using co-design, personalised care planning and family centred care to inform service improvements and care pathways (measured by adoption of Always Events methodology, complaints, Patient Advice and Liaison Service (PALS) concerns, public engagement events and user engagement in identified work streams). Improve the quality of discharge summaries ensuring a patient centred approach to discharge planning and pathways of care.
Priority 5	**Right Care, Right Time, Right Place** Strengthen collaborative working across the health and social care system to deliver sustainable improvements in care and in line with the Somerset Clinical Strategy, Fit for My Future (measured by involvement and progress with seven day services compliance, improving discharge, Somerset Sustainability and Transformation Partnership (STP) Programme Boards and work streams, and the Somerset Quality Improvement (QI) Faculty and Somerset Academy programmes of work).
Priority 6	**Staff Retention and Wellbeing** Develop a robust approach to staff retention across all staff groups with a focus on celebrating excellence in practice, promotion of wellbeing support and activities, opportunities for development and career progression within Somerset and across providers (measured by recruitment and retention metrics, staff survey results, delivery of workforce strategies and plans). Undertake job planning for Allied Health Professions (AHPs) and Clinical Nurse Specialists in line with NHS Improvement (NHSI) Levels of Attainment and to ensure safe staffing.

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 2018/19 key priorities were monitored via a dashboard presented to the Board and in quarterly quality reports to the Governance and Quality 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 some of these indicators is included in Part 3 of this Account.

Priority 1: Embed processes where investigation and learning occurs if care concerns have been identified and where these may have led to an adverse outcome for the patient (measured by HSMR, SHMI, SI's, National Audit of Care of the Dying, Mortality and LeDeR reviews).

2.3 Mortality

Throughout 2018/19 the Trust has used the Copelands Risk Adjusted Barometer (CRAB) and Dr Foster to provide outcomes data. The Clinical Outcomes Committee monitors outlier reports and analyses consultant and specialty level data. The mortality data provided by CRAB also informs the regular mortality and morbidity process allowing the team to review records where a risk or trigger has been highlighted.

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 lapses in care.

The Trust also seeks assurance through the Dr Foster Health Care Intelligence Portal. This system provides access to a wide range of key hospital quality and efficiency data providing an analysis of the patient's hospital journey from the Emergency Department to inpatients and outpatient activity. This tool provides multiple ways to analyse and assess hospital activity data which allows us to provide more effective and accurate decision making as we are able to better understand trends, emerging patterns and variations in patient outcomes.

Dr Foster data has enabled us to identify and understand potential quality of care issues and inefficiencies across several areas of the Trust including:

- In-hospital mortality
- A&E attendances
- Inpatient and outpatient admissions
- Length of stay
- Excess bed days
- Readmissions

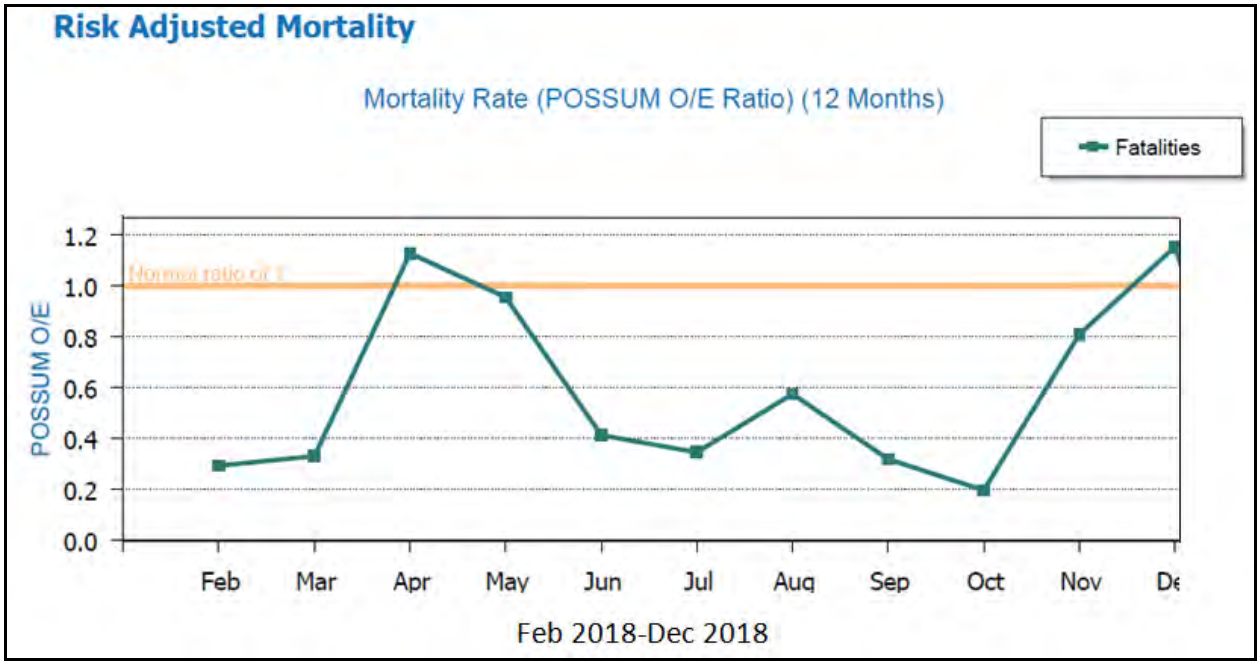
2.4 In Hospital deaths per month

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 2017 – December 2018 is **0.9624** with 1 being the expected norm**.** (The next data release is not due until June 2019).

The following graph shows risk adjusted mortality data over the last year in patients who have undergone surgery.



The normal mortality O/E (observed number of adverse outcomes / predicted number of adverse outcomes) ratio is 1.00. The Trust has remained mainly below this acceptable norm throughout the year with two peaks, one in April and one in December 2018. Drilling down into this data allows the Trust to identify any adverse outcomes and look at these in relation to the volume of procedures performed.

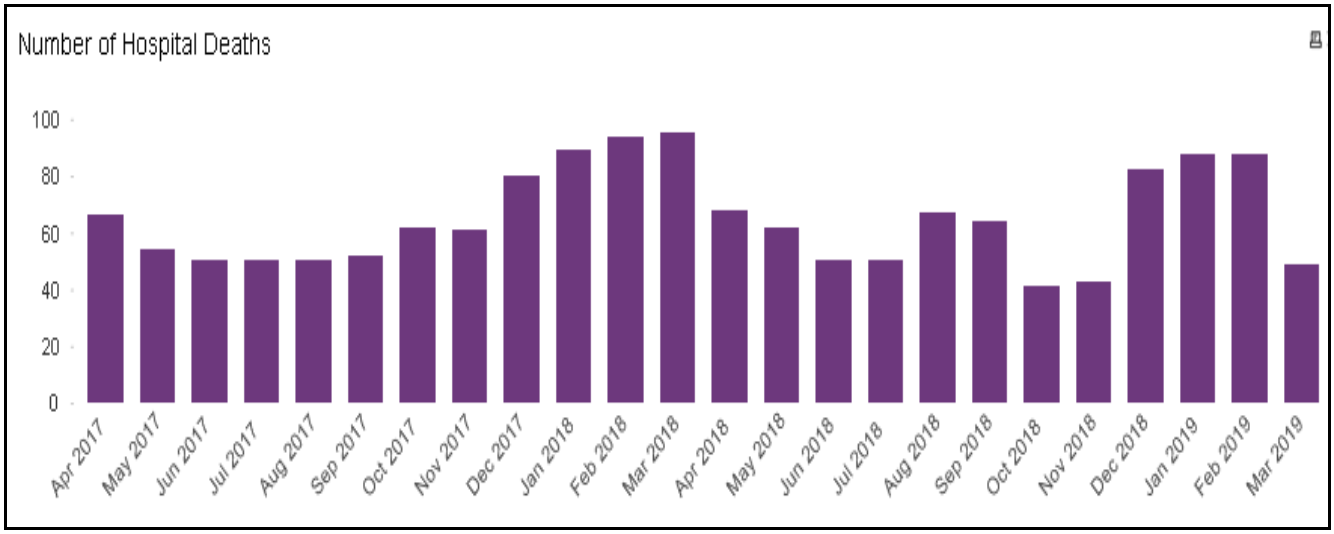
2.5 Hospital Standardised Mortality Rate (HSMR)

The Trust HSMR is 88.6 at the time of reporting and lower than expected range. This favourable position has been ratified and it is believed to be due to a combination of factors including the good practice of identification and management of patients at the end of life and efficient coding of patient comorbidities. This situation will be monitored through the Clinical Outcomes Committee on an ongoing basis.

2.6 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 Serious Untoward Incident, a complaint, a bereavement concern, a Learning Disability death (LeDer) review or formal mortality review using the SJR tool.

The following graph shows the number of deaths by month and demonstrates national and seasonal trends over the last and this financial year



During 2018/19 a total of 754 of Yeovil District Hospital patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

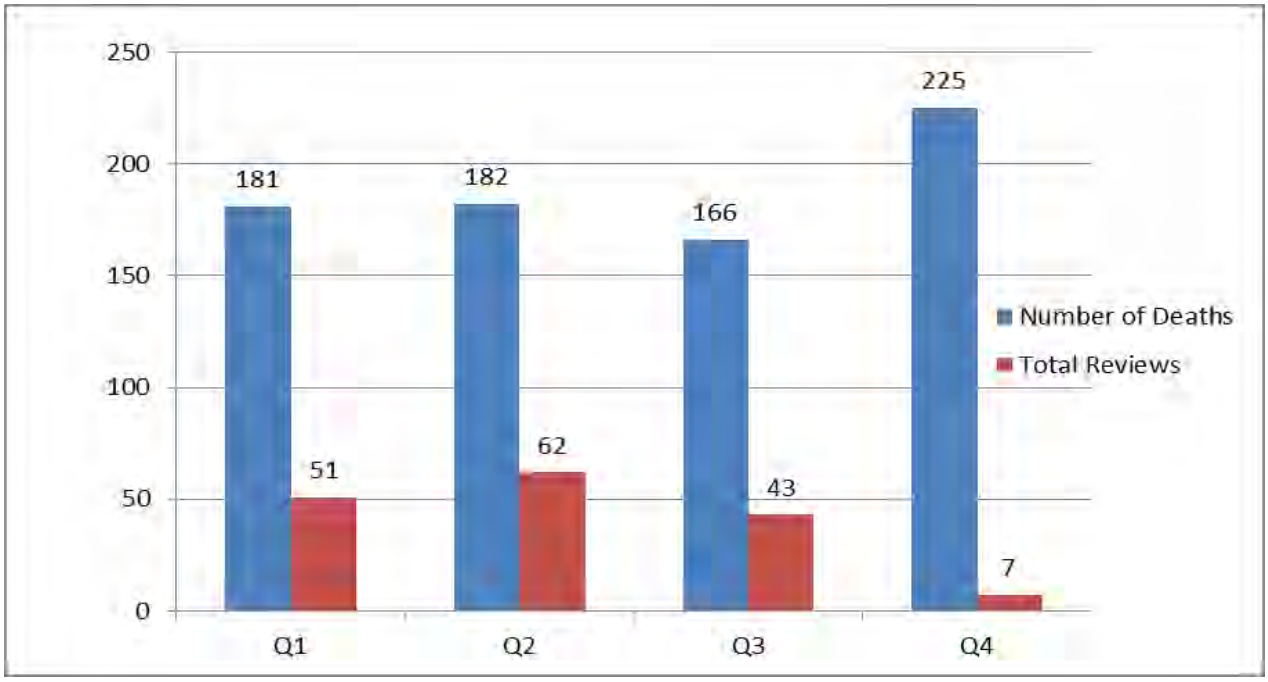
Period	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year End
No. of deaths	181	182	166	225	754
No. subject to review using the SJR	51	66	43	7	167
No. judged to be more likely than not to have been due to problems in the care*	1	0	0	0	1
% of deaths in the reporting period judged as more likely than not to be due to problems in care	0.55%	0%	0%	0%	0.13%

*This number has been calculated according to the scale contained within the Structured Judgement Review Tool and includes all cases rated 1-3 and includes 1 death as a result of a serious incident.

By 31 March 2019 167 case record reviews and 29 investigations have been carried out in relation to 196 of the in hospital deaths. (26% of all deaths). In no case, was a death subjected to both a case record review and an investigation.

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.

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 SJR tool 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

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 2018/19 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 Treatment Escalation Plan and Resuscitation Decision Record (TEPDNAR) both within the Trust and in partnership with the community;
- The need to ensure senior staff are equipped with the skills and confidence to have difficult conversations when recognising that patients are likely to be in their last year of life.

- The need to ensure patients are placed in wards with appropriately trained and competent staff during times of escalation.

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

- Discussion of cases at local Governance Meetings to inform decision making and learning;
- Commencement of Advanced Communication training for Senior Doctors, Nurses and Specialist staff
- Implementation of a revised End of Life Care plan to ensure symptoms and concerns are recognised and addressed.
- Simulation training with a range of scenarios whereby patients are likely to deteriorate.
- Development of specific care pathways to ensure safe placement of patients requiring post-operative care.

The actions taken have resulted in;

- Planned introduction of the Somerset Treatment Escalation Plan and improved agreements across health care settings to ensure patients receive the appropriate care in the right setting towards end of life;
- Trustwide implementation of an End of Life Care Plan, together with resource folders to improve access to relevant information and staff contacts
- Training of 20 Senior Staff in advanced communications skills are part of an ongoing programme of work

No case record reviews or investigations were completed after 31 March 2018 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. Coroner inquests can result in recommendations within prevention of future deaths notifications; the Trust has not received any of these within the reporting period.

Priority 2: Continuous reduction in avoidable harm (measured by incidence of pressure ulcers, falls, medication incidents, maternity safety metrics, implementation of NEWS2, compliance with sepsis CQUIN, SI's and Never Events, Safe staffing).

2.7 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 an average of 98% of patients being recorded as harm free in the period 2018/19.

2.8 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 no Never Events during 2018/2019.

NATSSIP's - National Safety Standards for Invasive Procedures have now been completed for the Trust and Local Safety Standards for Invasive Procedures (LocSSP's) completed where relevant. These are now available in a number of places on the intranet including the Patient Safety page. These safety standards are embedded in routine clinical practice and are audited on a rolling monthly basis both qualitatively and quantitatively to assure compliance. The Trust is now planning to roll out some of the principles involved in NATSSIP's to a number of other procedures within the trust.

The Trust was also invited to participate in last year's thematic review by the Care Quality Commission (CQC) into Never Events which was published in December 2018 -"Opening the Door to Change ".

The Trust has a renewed focus on the importance of human factors in team working and focusing on Near Misses to improve quality of care across the Trust.

2.9 Pressure Ulcer Prevention

We continue to follow the national agenda in the reduction of hospital acquired pressure ulcers. This year saw the implementation of NHS Improvement (NHSI) revised definition and measurement document. The purpose of the document is to support a more consistent approach to the definition of pressure ulcers at both local and national levels. This has been successfully rolled out across the Trust within the realms of training and support to the clinical staff.

Following the Trust participation in a national pressure ulcer prevention collaborative led by NHSI, the risk assessment tool was reviewed and replaced with a pressure risk tool, which comprises of six questions in relation to the factors associated with the risk of developing a

pressure ulcer. This facilitates preventative measures to be put in place in a timely manner and had full support from NHSI.

Preventative actions are a key focus in driving improvement and factor within assessment and ongoing care planning. At the end of the year, a total of 63 hospital acquired pressures ulcers (Grade 2 and above) were reported compared to 60 for 2017/18. Whilst this may indicate an increase, the national guidance confirmed a change in definition of hospital acquired pressure damage, thus including all incidents not identified on admission, as being attributable to the Trust. Therefore, this position represents an improvement on previous years' performance.

2.10 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.

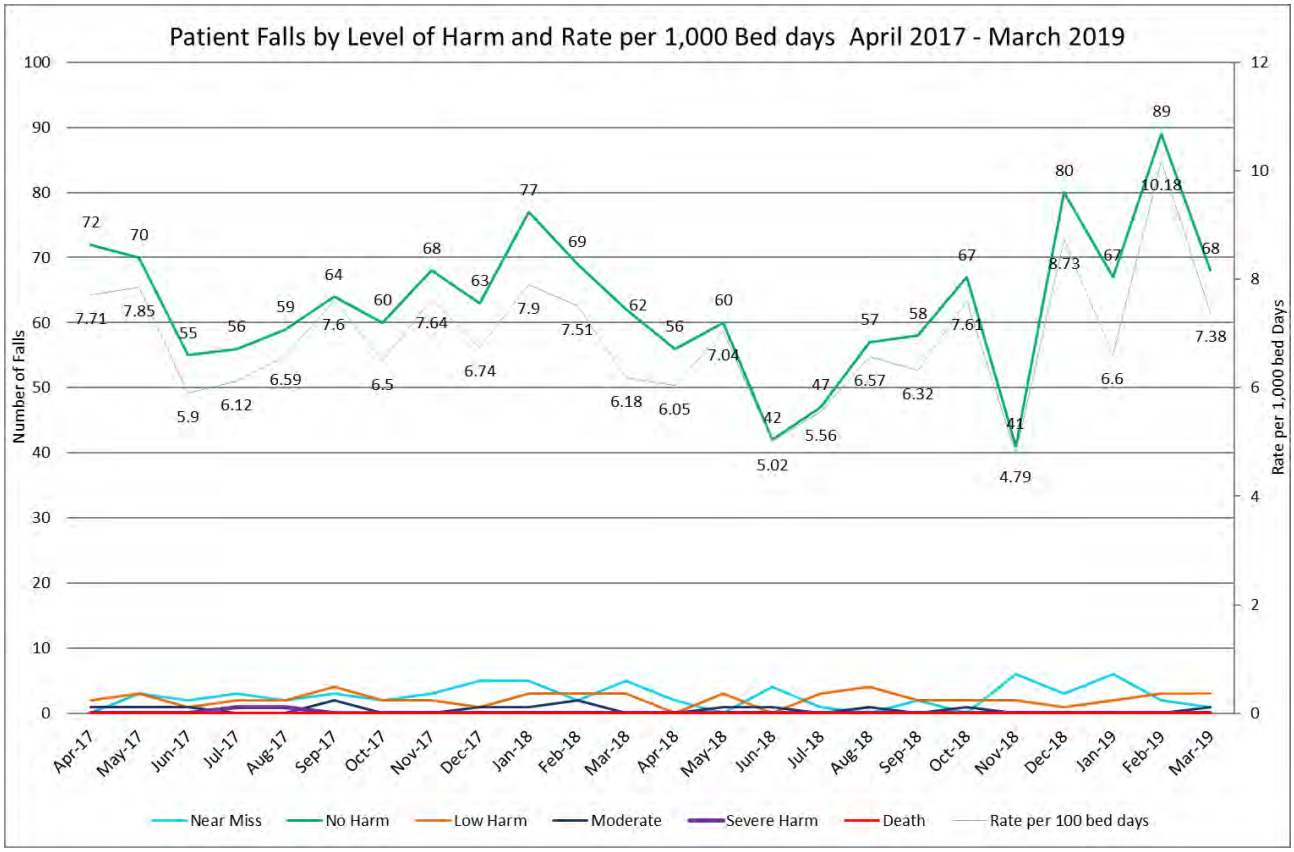
Falls co-ordinators continue to lead a multidisciplinary working group who meet monthly to oversee project work and respond to incidents as they occur. TagCare (a system of ensuring a group of patients who are deemed to be at high of falling are managed collectively by a ward based multidisciplinary team who have line of sight at all times in a bay) and co-horting of patients continues to be used and has become embedded in ward practice, forming part of the daily ward risk assessment and plan of care for high risk patients.

Regular training is offered via short ward based sessions to address preventative practice. In addition, falls training is offered to transition programme candidates (overseas recruits).

We are registered to complete the next phase of National Audit of Inpatient Falls which is focused on hip fractures sustained during an inpatient stay. A repeat internal re-audit of best practice is planned for spring 2019 and will continue to inform the focus of the future Falls work programme in the Trust.

The falls 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. Levels of harm are calculated using the National Patient Safety Agency (NPSA) risk matrix and in line 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 2018/19 was 7.82 which compares to 7.01 for 2018/19.

Overall the number of falls has decreased over the year with the final number for 2018/19 reported as 762 compared with 813 the previous year. This equates to a decrease of 6.2%. The rate of repeat fallers for the year was an average of 13%, compared to 14% in the previous year. Whilst there has been an increase in repeat fallers in the year at times this increase is reflected over the winter months when the Trust was in escalation. Winter plans for 2019/20 will recognise and work to address this increased risk. It is of note that this increase is reflected over the winter months when the Trust was in escalation.



2.11 Escalation

During 2018-19 Financial Year, there were 180 days when escalation beds were in use in the Trust, mainly during April 2018 and between January – March 2019. The ward most commonly used for escalation patients was Jasmine Ward (Open for 100 days in total first in April 2018 and then again during January - March 2019). The use of Jasmine Ward for escalation patients during winter 2018-19 was built into the Winter Plans and staffing planned in advance. Other areas that were used for escalation patients included use of additional opened capacity on Wards 9B, 7A and the Clinical Decision Unit. The opening of the Escalation Area in the recovery area of Day Theatres was minimised in order to reduce disruption to Day Surgery patients and was only open for 25 days mainly in Jan and Feb 2019. There were only 5 Cancelled Operations due to lack of Bed in 2018-19 and these were during the escalation periods in April 2018 and January 2019.

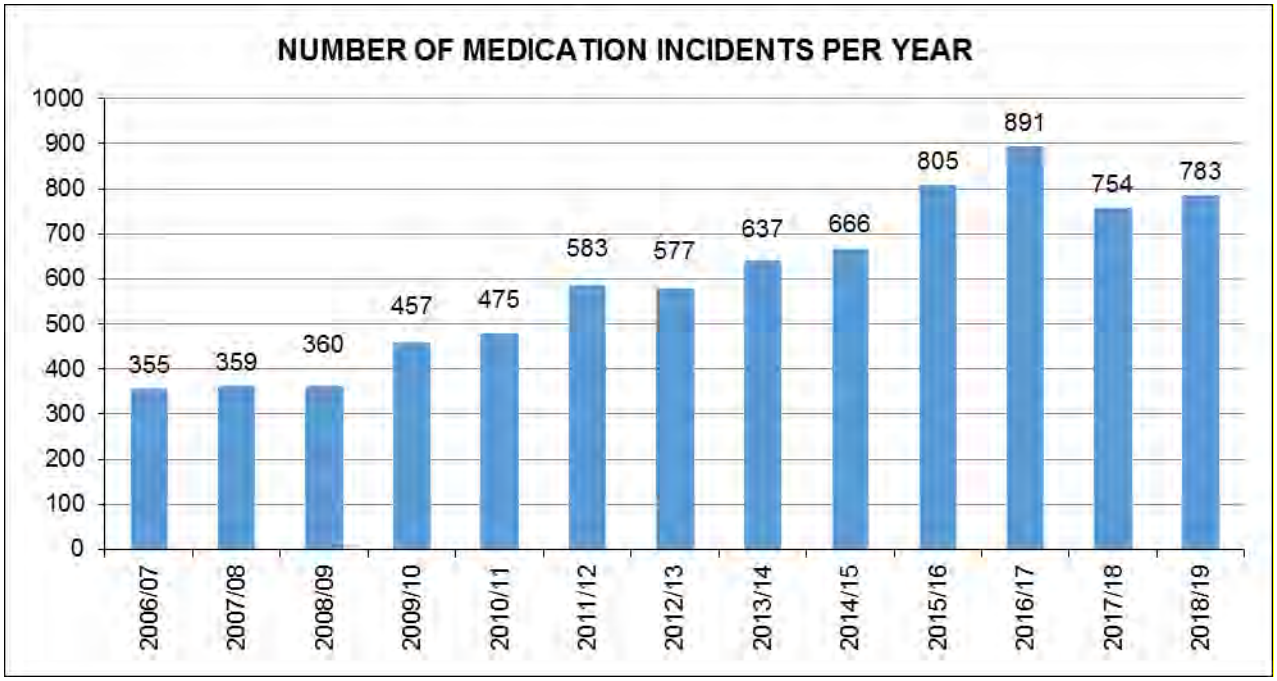
2.12 Safer Medicines

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 international normalised ratio (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 783 medication incidents reported over the last 12 months, 29.3% 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 2.6% 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 increased slightly and the figures remain high during 2018/19 this represents staff groups being encouraged to report all incidents to enhance our understanding and learning.



As stated the number of medication incidents linked to patient harm (or requiring medical intervention) remains low at 2.6%. This compares with data from 2017/18 which shows that 2.0% of all reported medication incidents were linked to patient harm (or required medical intervention).

The Drug and Therapeutics Committee and the Safer Medicines Group were merged during 2017/2018 to form the Trust's Medicines Committee. This Committee meets bi-monthly with an emphasis on assurance that systems relating to medicines are safe and effective. This assurance is underpinned by the Trust's new Medicines Optimisation Programme which includes a three year rolling audit plan covering all medication related Patient Safety Alerts to ensure continued compliance with these alerts. The Committee also oversees medicine related incidents, trend analysis and the identification of opportunities for learning; publication of regular medication related safety bulletins; Patient Group Directions (PGDs) and prescribing guidelines; and formulary applications for new medicines.

Pharmacy introduced the Trust's Medication Safety Assurance Audit, a mock CQC-style inspection concerned with the safe and secure storage of medicines within the Trust. The audit is also used as a tool to monitor for compliance with previous Patient Safety Alerts e.g. the availability of critical medicines and covers all clinical areas which stock medication. A number of key issues have been identified which have been addressed during 2018/2019 including damaged storage cupboards. All findings from the audit are shared with the Ward Matron and are reported to the Medicines Committee for further escalation if needed.

2.13 Healthcare Associated Infections (HCAI)

The implementation and maintenance of robust Infection Control practice remains a key action for the Trust in reducing avoidable Health Care Associated Infections (HCAI). Ensuring Infection Control policies and guidance are in place and implemented, is essential for confidence of all those that use the service and their families. Since 2008 there has been a legal requirement on the NHS and other health and social care organisations to implement the Health and Social Care Act 2008, and to meet the standards The Trust continued to sustain focus and energy on the Infection Control agenda, sharing key learning and best practice against the need for compliance with the HCAI National targets.

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. The Somerset wide multidisciplinary working group has continued to address this and a robust action plan has been followed. Unnecessary catheterisation of patients remained a focus and reduction was seen across the county. As further local target of a 10% reduction across Somerset within the 17/18 financial year was set.

The target for YDH was 19, this year ended with a YDH total of 23 - the same as 2017/18.

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 Data Capture System Mandatory Surveillance run by Public Health England.

2.14 Sepsis

Sepsis recognition and treatment at Yeovil Hospital continues to be an area of high importance. The screening tools and Sepsis 6 pathways that have been implemented are used in all areas and audited monthly. All life support courses delivered to clinical staff incorporate the recognition of Sepsis and the delivery of the Sepsis Six, a bundle of 6 measures that if all done within 1 hr of the recognition of sepsis have been shown to reduce mortality and morbidity significantly. Sepsis Star badges and certificates are awarded to staff that 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; we are now supplying Sepsis Stars to 16 other NHS Trusts in England.

It has been recognised locally and nationally that some patients present to medical help too late due to a lack of awareness of Sepsis, meaning that despite the best efforts of the staff, sometimes there is nothing that can be done for these patients. In response to this we have commenced a public awareness campaign including the development of the Sepsis Lift in the main lift area, the graphics prompt people to ask the question 'Could this be Sepsis?' We are also working with local community services and delivering sepsis awareness sessions in the community.

Another issue that is becoming more apparent since awareness of sepsis has increased is the long term consequences that some patients suffer, these can manifest as physical, psychological or emotional problems, or a combination of them all. With the support of the UK Sepsis Trust and in collaboration with other Trusts we have set up the Somerset Sepsis Support Group that rotates monthly between Yeovil District Hospital, Taunton & Somerset, Weston General Hospital and now Somerset Partnership. These meetings are open to all who have been affected by sepsis and have been well evaluated by those that have attended.

The Trust collaborates closely with other organisations including the Somerset Clinical Commissioning Group Sepsis Working Group, with colleagues from across the county in primary and secondary care, and also links 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).

Please see below for the Sepsis audit results for Q1-Q4.

2018-2019	2a(i) ED screening	2a(ii) Inpatient Screening	2b(i) ED Antibiotic Administration	2b(ii) Inpatient Antibiotic Administration
Q1				
April	100%	96.25%	75%	100%
May	99%	78.40%	75%	100%
June	98%	88.70%	81.80%	100%
Q1 Average	98.70%	87.60%	77.80%	100%
Q2				
July	100%	98.80%	100%	N/a
August	100%	93.75%	66.70%	N/a
September	100%	96.65%	75%	100%
Q2 Average	100%	93.30%	81.80%	100%
Q3				
October	97.50%	96.70%	66.70%	50%
November	100%	97.10%	83.30%	100%
December	97.50%	99.05%	100%	100%
Q3 Average	98.70%	96.10%	84.20%	80%
January	100%	95.50%	85.70%	100%
February	100%	87.80%	75.00%	100%
March	100%	82.00%	80.00%	100%
Q4 Average	100%	88.10%	83.10%	100%
Year Average	**99.30%**	**91.80%**	**81.20%**	**93.3**

2.15 Neutropenic Sepsis

Neutrophils respond early to injury or infection. They have a role in both directly killing non-host cells such as bacteria by phagocytosis and activating other parts of the immune system. Cytotoxic anti-cancer chemotherapy is designed to kill neoplastic cells by damaging the DNA irreparably. For most chemotherapy regimens, the neutrophil count falls to its lowest level approximately 5-7 days after administration and can take up to 2-4 weeks to recover, although for some drugs, these timescales are considerably different. Novel biological agents generally have a lower rate of neutropenia but, such problems can still occur.

When neutropenic, the patient is vulnerable to infection this can potentially cause overwhelming sepsis and death. Deterioration can be very rapid, sometimes without an obvious focus for infection. Reported mortality for untreated neutropenic sepsis ranges from 2 to 21% but is poorly reported nationally. Neutropenic sepsis is therefore considered a medical emergency, and as with severe sepsis, there is widespread agreement that early administration of broad spectrum antibiotics is key to successful management.

Patients starting chemotherapy have historically always had a pre-chemotherapy education session which included the signs of Neutropenic Sepsis and what to do if they occurred. From May 2018 Neutropenic Sepsis Alert cards were developed and given to patients along with this session including the warning signs and information for admitting departments. A Neutropenic Sepsis Screening and Action tool has been implemented for both Ambulatory care and the Emergency department over the last 2 months (Q3/4) to help identify and treat these patients more promptly. Our audit results for 'Door to Needle time' in suspected neutropenic sepsis have improved month on month during the 2018/19 period with the implementation of the above along

with an increase in staff teaching sessions. In Q1-Q3 we on average achieved 56%, 68% and 77% respectively. This continued to improve with an average result in Q4 of 90%.

2.16 Recognition and Rescue of the Deteriorating Patient

A part time Simulation Fellow post was introduced at Yeovil District Hospital in February 2016/17 with the aim of establishing multi-disciplinary simulation teaching programmes to reduce incidents of failure to detect, communicate or respond to deterioration.

Simulation teaching allows our staff to train in a safe and supportive environment. In situ simulations have the added benefit of testing systems. There has been a dramatic increase in simulation in the medical undergraduate/post graduate programmes. With this increase in demand the Simulation Fellow post was made full time in December 2018.

Simulation at YDH includes the delivery of the following;

- Ward based simulations adult and paediatric;
- Simulation is embedded into F1/F2 doctor teaching on a weekly basis
- Undergraduate teaching programmes, all years
- Real time trauma/emergency simulations in our Emergency Department
- Real time maternal simulations
- Operating department simulations
- Development of end of life simulations to aid our staff with difficult conversations
- A Dr “on-call” Simulation to help our new Doctors familiarise with our systems

In line with the Trust’s strategic priorities to innovate and collaborate we are taking simulation to our primary care colleagues. The programme, funded through a successful bid to Heath Education England, will focus on the deteriorating patient in the community setting. This includes nursing homes and GP surgeries. A key aspect will be the introduction and implementation of NEWS2, which advocates a system to standardise the assessment and response to acute illness. This will aid communication and escalation between all health care providers.

2.17 Safe Staffing

In 2013 the National Quality Board set out 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. During 2018/19, we have undertaken an audit of adult inpatient wards using the Safer Nursing Care Tool and identified the need to increase the whole time equivalent numbers of staff on four wards, 7A (Surgery), 8A (Cardiology), 9A (Respiratory/Endocrinology) and 9B (Gastroenterology). Additional funding has been secured from the STP to staff these wards as indicated by the increased acuity of the patients. Recruitment is underway to fill these additional posts.

The Trust has implemented twice daily acuity scoring on all adult wards to inform safe staffing decisions at the Patient Flow meetings. The SafeCare module of the e-roster (electronic staffing) system has been deployed to ensure robust audit supports professional judgement when making decisions about staffing levels. A Safe Staffing policy has been ratified to support a risk based approach and to ensure director level approval of high cost agency requirements.

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 according to the acuity of the patients, staffing levels and skill mix of registered and unregistered staff.

The organisation is committed to investing in new roles and was successful in being a Fast Follower for the Nursing Associate pilot with candidates who commenced in post April 2017. The first cohort of trainees is due to qualify in April 2019 and will join the Nursing and Midwifery Council (NMC) register in June 2019. A further two cohorts are in training. Quality Impact Assessments have been completed, in accordance with National Quality Board and NHSI Developing Workforce Safeguards guidance, where new roles or skill mix reviews have been implemented.

Actions to address nursing gaps include assessment of workload and patient acuity. We use;
The SafeCare Model of our e-roster system and senior professional judgement to review the skill mix and requirements to meet the minimum staffing levels. To secure additional temporary staff we also look at the internal redeployment of staff working in other areas but with transferrable skills and knowledge, and escalation, in accordance with the Trust Safe Staffing policy,.

Priority 3: 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, number of mental health first aiders, establishment of Psychiatric Liaison pathways).

2.18 Countywide Psychiatric Liaison Service

The Countywide Psychiatric Liaison Service has been in place since the beginning of the financial year. The service is funded by the Somerset Clinical Commissioning Group (CCG). The service has developed iteratively to embed a system and process to ensure rapid assessment, provide appropriate intervention and timely discharge of patients presenting with physical and mental health needs.

YDH contributed to a Rapid Improvement Event facilitated by NHS England that considered Children and Young People experiencing a delay in discharge / transfer of care. This led to a number of work streams such as the development of a draft joint protocol for children and young people who present to the Emergency Department with a mental health need or are known to

children social care and further implementation of the deliberate self harm protocol and guidelines to be used across the county, this work is ongoing.

Additional investment has been made to extend Somerset Partnership's delivery of on-site CAMHS support to extend opportunities for initial assessment, intervention and appropriate discharge until 20:00hrs Monday – Friday in addition to off-site out of hours support. Challenge remains in recruiting to these posts to ensure a robust and reliable service is provided, locally. In Quarter 4, the Sustainable Transformation Programmes Board approved additional funding for the CAMHS Complex Care Practitioner and the Trust recruited to a Band 6 post for an initial period of one year. The post holder, Paediatric Service and Emergency Department will continue to work collaboratively with Somerset Partnership NHS Foundation Trust to deliver continuous improvements for children and young people with mental health needs. Paediatric staff continue to support the County wide Eating Disorder pathway.

2.19 Mental Health First Aid (MHFA)

In April 2018 the Trust Mental Health Lead carried out the Mental Health First Aid (MHFA) Train the Trainer course which was funded by NHS Improvement. This course provides staff with the knowledge and skills to be competent in dealing with patients and/or staff who are experiencing a mental health crisis.

2.20 Mental Health Commissioning for Quality and Innovation (CQUIN)

A considerable amount of work has continued as a result of the Mental Health CQUIN in the year to develop co-designed management plans for high impact users in the Emergency Department. The Trust achieved a 53% reduction in attendance of this cohort of patients at the end of Quarter 4.

2.21 Conflict Resolution

300 staff received training in conflict resolution during the year.

Priority 4: 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, PALS concerns, public engagement events and user engagement in identified work streams).

2.22 Patient Engagement

The Trust has a valued and responsive Patient Experience Team who engage with partner organisations in the local community to gain insight and feedback from the local population. The team ensures representation at the County wide Complaints Managers Meeting, Head of Patient Experience Network, Somerset 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, and continues to develop an ever increasing network.

The Patient Experience and Engagement Lead provides a calendar of events, which includes all community support groups and support within the trust. The first Esther café event was held in January 2019 regarding end of life care, where patients and or family members can share experiences with clinical and other staff. Ward Staff and a Governor were able to attend to listen to the relative's story. Feedback was very positive and staff felt they would be able to alter some of their practice so that it was more patient focussed and everyone identified that communication was key.

The Patient Voice group (a group of volunteers) provides an opportunity for the organisation to test the learning and actions arising from complaints. The Chair of this group 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.

2.23 Patient Feedback

The Friends and Family test is captured using an online system called "IwantGreatCare". 'IwantGreatCare' this allows the Trust to listen to patients. Feedback is captured at ward and department level and the system has enabled staff to capture feedback at individual clinic level.

During March 2019, the FTT survey was tested with an in house system on one ward, and managed via the SNAP survey software. This was successful, therefore the survey will move to be completely in house as of April 2019, with a focus on encouraging and improving feedback from our patients so that we can make any necessary changes. In addition business cards have been developed allowing patients to complete the survey when they return home, volunteers have agreed to help by distributing these when they are present on the wards. Posters have been developed advertising the survey and encouraging patients to leave any feedback.

2.24 Patient Experience

The Complaints and PALs process has been reviewed in the year. Recognising opportunities for efficiencies. All complainants are now offered an early intervention contact to discuss the concerns early and to agree expected outcomes and time frames for any investigations. This has led to more timely closure of investigations with some cases being closed after the early intervention meetings. All complaint responses now provide a decision about whether the complaint is upheld, partially upheld or not upheld. Where complaints are identified as upheld actions 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 monitored at an operational level via the electronic complaints system by the Ward Sister and Matrons to ensure compliance. The actions and themes are also monitored at the Patient Experience and Engagement Steering Group.

Priority 5: Strengthen collaborative working across the health and social care system to deliver sustainable improvements in care and in line with the Somerset Clinical Strategy, Fit for My Future (measured by involvement and progress with seven day services compliance, improving discharge, Somerset Sustainability and Transformation Partnership (STP Programme Boards and work streams, Somerset QI Faculty and Somerset Academy programmes of work).

2.25 Somerset Academy and Somerset Quality Improvement Faculty

The Trust has actively participated in the development of the next cohort of the Somerset Academy to ensure that delivery of transformative service development, to inform and shape future joint commissioning, is explicitly linked to Sustainable Transformation Programmes priorities and Fit for My Future, the Somerset Health and Care Strategy.

The Somerset Quality Improvement Faculty has been strengthened with additional membership from Primary Care and the Trust has led on a number of Quality Improvement Projects including implementation of a countywide Ultrasound guideline to improve the quality of diagnostic requests and timeliness of provision, and the introduction of NEWS2 and sepsis screening in the GP Emergency Medical Referral pathway. The projects continue at the time of reporting.

2.26 Seven Day Services

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:

- Clinical Standard 2 – Time to first consultant review;
- Clinical Standard 5 – Access to diagnostic tests;
- Clinical Standard 6 – Access to consultant-directed interventions;
- Clinical 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;
- 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.

In spring 2018 the Trust audited 143 sets of notes against the four core standards, the results are shown below:

CS2 Time to first consultant review;	CS5 Access to diagnostic tests;	CS6 Access to consultant-directed interventions	CS8 Ongoing review by consultant twice daily if high dependency patients, daily for others.
91%	100%	100%	98%

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

	Survey			
	September 2016	March 2017	September 2017	April 2018
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	92%	89%	70%	91%

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:

- Budgeting for an eighth general surgeon
- Pathways are under development for emergency surgery ambulatory care and ED
- The scheduling of CEPOD (a permanently staffed operating theatre that can run on a 24 hour basis) sessions has been reviewed
- Working with the Deanery to improve junior on-call at night from August 2019
- Increased use of the Model Hospital to identify areas of variation for length of stay
- Job plans in gynecology were changed to ensure twice daily ward rounds.
- Seven day Gynecology Assessment Unit, embedded ensuring that patients see a consultant or middle grade as part of the admission and a standard operating procedure is being developed to formalise this pathway
- There are ongoing discussions at Somerset Sustainability and Transformation Partnership (STP) level regarding the future provision of paediatric services across Somerset, this includes how seven day services can be sustainably provided

2.27 Discharge Improvement

Throughout the year the Trust has worked collaboratively to improve discharge this work is being managed and monitored by a QI task and finish group. This will continue and is focused around the following workstreams:

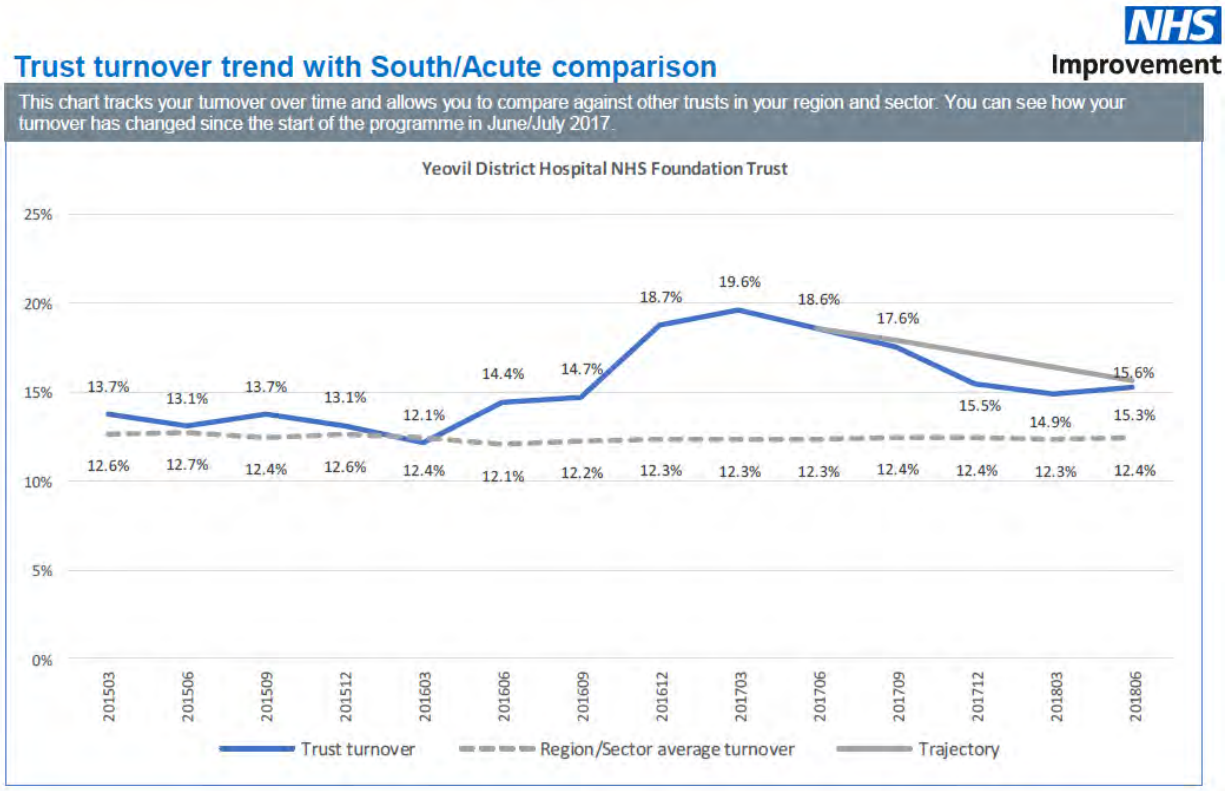
- Development of a discharge checklist that is being trialed, the aim is to standardise documentation and ensure all key elements of a successful discharge are considered.
- Development of a patient information leaflet and resource folder with key information, supporting patients and families to prepare for discharge.
- Successful introduction of ward based dispensing, which has demonstrated a significant reduction in the time taken to dispense 'tablets to take out'
- Increasing the number of non-medical prescribers and nurse transcribers to improve the process and content of discharge summaries
- Discharge summary review of content, and the process for timely completion and sharing with relevant others

Priority 6: 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 metrics, staff survey results, delivery of workforce strategies and plans).

2.28 Recruitment and Retention

In August 2017 we began working on an extensive action plan with the target of reducing our turnover. The work covered many actions in the following headings: Culture and Leadership, Personal and Career Development, working environment, Engagement and communication, recruitment and Health and Wellbeing. This has led to a 3% decrease in our turnover within 12 months.

The chart below details quarterly turnover rate for Registered Nurses and Midwifery staff at Yeovil District Hospital NHS Foundation Trust and our region/sector average. The grey solid line is our planned improvement trajectory.



2.29 Doctors in training rota gaps

In August 2018 there were 7 vacant training posts (Rota Gaps): 7 x F2 doctor posts. In September 2018 this increased to 10 vacant training posts adding 2 x ST4 Paeds, 1 x ST3 Gastro.

Rota gaps occur due to the Deanery being unable to fill their posts nationally and supply Doctors to the Trust.

When the deanery completes their national recruitment any posts they fail to fill are highlighted to trusts for them to complete recruitment at trust level.

In order to make the posts at YDH more attractive we are redesigning rotas and ensuring those recruited at trust level are able to access the same training opportunities.

2.30 Staff Survey 2018

The results of the 2018 Staff Survey show that the Trust continues to improve and we are above average in virtually every area. Our response rate was 71%, which is the highest of any acute trust in the country. The average was 44%.

We are also the best Trust in the country for staff health and wellbeing, and we are in the top 20% of NHS Trusts for a number of other important areas:

- Diversity and inclusion
- Support from managers
- Staff morale
- Safety of the hospital environment
- Bullying and harassment
- Staff Engagement

Headline results show us that:

- 65% look forward to coming to work (average 58%)
- 79% are able to suggest improvements (average 74%)
- 78% feel supported by their manager (average 69%)
- 78% feel valued (average 71%)
- 95% feel YDH takes positive action on H&WB (average 89%)
- 70% recommend YDH as a place to work (average 60%)
- 74% would recommend YDH as a place to receive care (average 68%)

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

- 21% experienced violence from patients (average 15%)
- 79% have had an appraisal (average 87%)

We are determined to continually improve and make Yeovil Hospital an ever better place to work, and to support this we have put in place many organisational development programmes. Two key programmes have focused on developing Health & Wellbeing initiatives, and investing in our leaders to help them improve their management skills and become even better at supporting and developing their people.

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

2.31 Participation in National Clinical Audit and Confidential Enquiries

During 2018/19 there were 39 national clinical audits and 5 national confidential enquiries that covered relevant health services that Yeovil District Hospital provides. During that period Yeovil District Hospital participated in 95% of relevant national clinical audits and relevant 100% national confidential enquiries of those in which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Yeovil District Hospital participated in and for which data collection was completed during 2018/19 are listed below alongside the number of cases submitted to the 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 and Provider Organisation	Cases submitted
Myocardial Ischaemia National Audit Project (MINAP) National Institute for Cardiovascular Outcomes Research (NICOR)	Continuous audit of all eligible patients
National Heart Failure Audit National Institute for Cardiovascular Outcomes Research (NICOR)	Continuous audit of all eligible patients
National Emergency Laparotomy Audit (NELA) Royal College of Anaesthetists	Continuous audit of all eligible patients
Inflammatory Bowel Disease Programme/IBD Registry Inflammatory Bowel Disease Registry	730 – in process of populating registry retrospectively
Sentinel Stroke National Audit Programme (SSNAP) Royal College of Physicians	Continuous audit of all eligible patients
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme British Thoracic Society	Continuous audit of all eligible patients
Adult Community Acquired Pneumonia British Thoracic Society	All eligible patients
Non-invasive Ventilation – Adults British Thoracic Society	All eligible patients
National Comparative Audit of Blood Transfusion Programme NHS Blood and Transplant	100% minimum requirement
Serious Hazards of Transfusion (SHOT) UK National Haemovigilance	Continuous audit of all eligible patients
National Diabetes Audit – Adults (NDA)	Continuous audit of all

NHS Digital	eligible patients
National Pregnancy in Diabetes Audit (NPID) NHS Digital	Continuous audit of all eligible patients
National Paediatric Diabetes Audit (NPDA) Royal College of Paediatrics and Child Health	Continuous audit of all eligible patients
UK Cystic Fibrosis Registry Cystic Fibrosis Trust	Continuous audit of all eligible patients
National Audit of Seizures and Epilepsies in Children and Young People Royal College of Paediatrics and Child Health	Continuous audit of all eligible patients
National Neonatal Audit Programme Royal College of Paediatrics and Child Health	Continuous audit of all eligible patients
Seven Day Hospital Services NHS England	100% minimum requirement
Learning Disability Mortality Review Programme (LeDeR) University of Bristol Norah Fry Centre for Disability Studies	Continuous audit of all eligible patients
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis British Society for Rheumatology	Continuous audit of all eligible patients
National Audit of Dementia Royal College of Psychiatrists	100% minimum requirement
National Audit of Care at the End of Life (NACEL) NHS Benchmarking Network	100% minimum requirement
National Maternity and Perinatal Audit (NMPA) Royal College of Obstetricians and Gynaecologists	Continuous audit of all eligible patients
Maternal, Newborn and Infant Clinical Outcome Review Programme MBRRACE-UK, National Perinatal Epidemiology Unit	Continuous audit of all eligible patients
National Cardiac Arrest Audit Intensive Care National Audit and Research Centre	Continuous audit of all eligible patients
Case Mix Programme (CMP) Intensive Care National Audit and Research Centre	Continuous audit of all eligible patients
Falls and Fragility Fractures Audit Programme ((FFFAP) Royal College of Physicians	Continuous audit of all eligible patients
Major Trauma Audit The Trauma Audit and Research Network	Continuous audit of all eligible patients
National Joint Registry (NJR) Healthcare Quality Improvement Partnership	Continuous audit of all eligible patients
National Ophthalmology Audit Royal College of Ophthalmologists	Continuous audit of all eligible patients
Feverish Children Audit Royal College of Emergency Medicine	45 patients (38%)
Vital Signs in Adults Audit Royal College of Emergency Medicine	75 patients (63%)
VTE Risk in Lower Limb Immobilisation Royal College of Emergency Medicine	All eligible patients (33)
National Audit of Breast Cancer in Older People Royal College of Surgeons	Continuous audit of all eligible patients
National Prostate Cancer Audit Royal College of Surgeons	Continuous audit of all eligible patients
National Bowel Cancer Audit NHS Digital	Continuous audit of all eligible patients
National Oesophago-gastric Cancer Audit NHS Digital	Continuous audit of all eligible patients
National Lung Cancer Audit Royal College of Physicians	Continuous audit of all eligible patients

During 2018/19 the Trust was eligible to enter data into the following 5 NCEPOD studies:

Study Name	Cases Included	Progress
Cancer in Children and Young Adults	0	Awaiting report
Perioperative management of surgical patients with diabetes	6	Report disseminated for review
Pulmonary Embolism Study	3	Awaiting report
Acute Bowel Obstruction Study	6	Awaiting organisational questionnaire to complete
Long-term Ventilation Study	0	Awaiting organisational questionnaire to complete

2.32 NICE Quality Standards

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

NICE Quality Standards are designed to drive quality improvement and are derived from NICE Guidance and other evidence sources accredited by NICE.

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

Guidance	Number published – Total No.(No. during 2018/19)	Fully Compliant
Quality Standards	161 (16)	61

Quality Standards that are partially compliant include:

NICE Quality Standard 33 – Rheumatoid Arthritis

National audit results highlight the following two areas for improvement: People with suspected persistent synovitis affecting the small joints of the hands or feet, or more than one joint, are referred to a rheumatology service within 3 working days of presentation. People with suspected persistent synovitis are assessed in a rheumatology service within 3 weeks of referral.

NICE Quality Standard 56 – Metastatic Spinal Cord Compression (MSCC)

Local audit results highlight the following area for improvement: Adults with suspected MSCC who present with neurological symptoms or signs have an MRI of the whole spine and any necessary treatment plan agreed within 24 hours of the suspected diagnosis. Patients admitted out of hours, over the weekend, are transferred to another hospital.

NICE Quality Standard 104 – Gallstone Disease

There is full compliance with this standard except in the following area when it is sometimes not met: Adults with acute cholecystitis have laparoscopic cholecystectomy within 1 week of diagnosis.

Action Plan – Measures to meet recommendation ambulatory care, acute surgical pathway and the appointment of an eighth consultant.

NICE Quality Standard 105 – Intrapartum Care

Local audit results highlight the following area for improvement: Women at low risk of complications during labour are given the choice of all 4 birth settings and information about local birth outcomes.

Action Plan – Review information provided at booking. Create a handout / text message / internet link about the local provision for the four places of birth and about our key outcomes to women which is updated every quarter.

NICE Quality Standard 125 – Diabetes in Children and Young People

There is full compliance with this standard except in the following area when it is sometimes not met: Children and young people with type 1 diabetes who have frequent severe hypoglycaemia are offered ongoing real-time continuous glucose monitoring with alarms.

Action Plan: Continuous glucose monitoring if recommended has to be funded by patient. Negotiations are taking place jointly with Musgrove Park Hospital to produce funding criteria in line with the NICE Guidelines.

2.33 Participation in Local Clinical Audits

A total of 101 local clinical audits and surveys were registered in Clinical Governance during 2018/19. The reports of 39 (39%) completed local clinical audits were reviewed by the provider in 2018/19 and Yeovil District Hospital intends to take the following actions to improve the quality of healthcare provided.

Re-audit of CT Reporting Time in Head Injury

The aim of the audit is to determine the time duration from the CT scan acquisition to the provisional or final report available on the Primary and Acute Care Systems (PACS) and whether it is in accordance with NICE guidelines. NICE recommends – a provisional radiology report should be made available within 1 hour of the scan being performed.

Key findings:

- Out of the 79 CT reports, 76 were reported within one hour which corresponds to 96.2 % following the NICE guidelines.
- There is significant improvement in the reporting time as compared to previous study 88% though the target was not achieved.

Action plan:

- Presenting this audit in clinical group meeting
- Discussions with all CT reporting radiologists
- Re-audit in 3-6 months' time

Re-audit of thyroid U scoring and subsequent fine needle aspiration cytology (FNAC)

The aim of the audit is to determine whether ultrasound reporting and treatment meets the British Thyroid Association (BTA) guidelines 2014 that recommend all thyroid ultrasounds include a U-score. U1 - U2 should not have FNAC. U3 - U5 nodules should have FNAC.

Key findings:

- There is significant improvement in the quality of ultra-sounding (US) Thyroid reporting by 100% mentioning on U scoring as compared to previous data of 82% and there is subsequent FNA procedure for 98% of the cases with indeterminate nodules.

Action plan:

- Email this re-audit to all the radiologists and sonographers who are performing US thyroids
- Presentation and discussion in upcoming clinical governance

Cystistat/Ialuril Audit

The aim is to review the pathway of care for this group of patients to ensure best practice by increasing self-care and education before invasive treatments are considered and ensure regular reviews. This should provide a cost saving due to reduction of expensive intravesical treatments currently being offered as first line treatments.

Recommendations:

- All Patients referred to the Clinical Nurse Specialist should be seen for lifestyle advice and education before starting invasive treatments
- A local agreement should be made as to what first line treatments are available before starting second line treatments such as cystistat and ialuril
- Patients should be reviewed at least yearly by a urologist to agree that treatment should continue and discuss alternative options
- All patients should be offered the option of self-administration if appropriate

Action plan:

- Present findings to urology team for feedback and to agree new pathway
- Re audit in 12 months
- Provide a patient education document at diagnosis to empower patients to self-manage their condition

Emergency Admission Audit

The aim is to assess compliance with national guidance on medical review of Emergency admissions in Obstetrics and Gynaecology departments within a specified time period. To oversee the development of standards and care pathways for patients with emergency care needs and to ensure uniform adoption of best practice.

Key findings:

- The performance level in the management of emergency admissions in Obstetrics and Gynaecology at YDH has significantly improved following the implementation of changes in the clinical practice, which reflects enhanced service provision and better patient outcome

Action plan:

- Further audit required to ensure the target of 100% is met by March 2020

Delirium and sedation on the Intensive Care Unit Audit

The aim is to review current practice on the Intensive Care Unit with local guidelines.

Key findings:

- Areas for improvement were identified including training and review of protocols

Action plan:

- Education of nursing and medical staff:
- Importance of appropriate sedation
- RASS to be prescribed on morning round
- RASS documented every hour
- Increasing frequency and documentation of sedation hold
- Importance of CAM-ICU
- Update of delirium and sedation protocols:
- Change sedation to include pain scores / remove cooling / to start music therapy
- Ensuring easy access of protocols on ICU and via intranet
- Re-audit in 2019

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

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 Audit

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 Audit

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.

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:

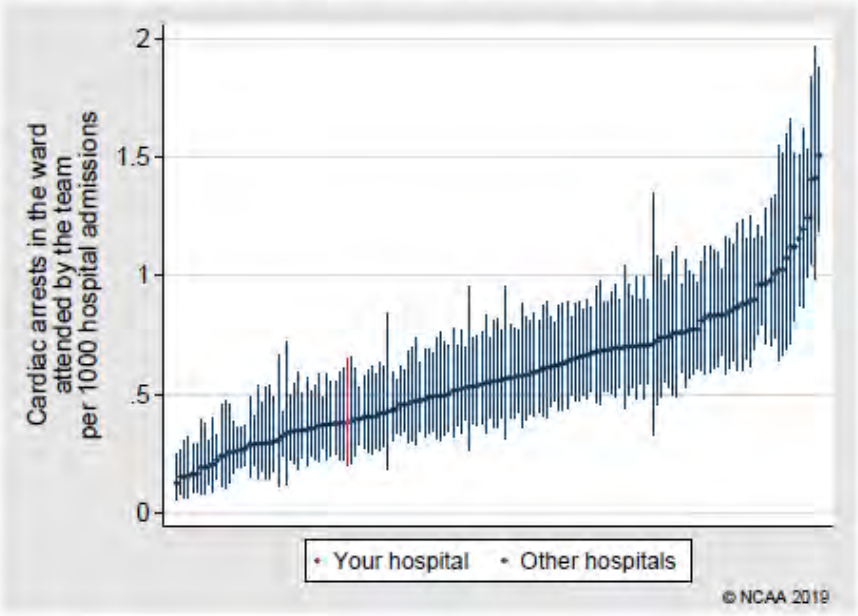
- Redesign of the acute admission clerking proforma to include a delirium screen and a frailty scoring system;
- Development of a Dementia strategy and workplan to ensure ongoing improvement and monitoring by the Dementia Steering Group;
- Additional improvements to the built wards and departments to 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.

National Cardiac Arrest Audit (NCAA) (Quarter 3 April 2018 December 2018)

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.



NCAA report for quarter 3 (Apr to Dec '18) Compared to 2017 figures in brackets.

For a total of 34,254 (33,712) admissions:

- There were 31 (62) calls for in-hospital cardiac arrests
- The number of in-hospital cardiac arrests per 1000 admissions has significantly improved, approximately 0.9 (1.8)
- 42% (61%) were age 75+ - much improved, mean age is on a downward trend.
- We have had more arrests in the more acute areas than NCAA expects:
- ED – 5
- ICU – 11 (recognising the deteriorating patient early & transferring to ICU)
- Less on the wards than expected – 13
- Survival to hospital discharge is currently 26.7% (26.4%)

2.34 Research and Development

The number of patients receiving NHS services provided or subcontracted by Yeovil District Hospital NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1260. 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 Trust is a partner organisation of the National Institute for Health Research (NIHR) South West Peninsular Clinical Research Network.

There are presently 86 studies open and recruiting, inclusive of randomised clinical trials, observational studies, 21 on follow up and 1 sponsored and led by the Trust. These studies are

distributed over many clinical specialties and we provide support to our clinical colleagues to assist with the running of these studies and the development of new innovative ideas. 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. This ensures that our clinical staff are aware of the latest possible treatment opportunities and give patients the best possible outcomes.

We are in receipt of a NIHR Research for Patient Benefit Grant for £245000 for Professor Nader Francis to run a multicentre study looking at volatile biomarkers in colorectal cancer which is a Trust Sponsored study and aims to recruit 600 patients nationally which is currently recruiting well.

We have 2 medical research fellows that assist Prof Francis in running the grant and submitting abstracts and future grants. We are in receipt of funding from the South West Pen to host a non-medical research fellow post to assist with patient recruitment and to develop their own research idea and disseminate research within the Trust. A specialist dietician was successful in her application and continues to develop her interest in Nutrition post Critical Care and has presented her work nationally and had developed international collaborations within this area.

We actively encourage patient involvement and celebrated with an afternoon tea event in September that saw patients and Trust staff talk about their research experiences in a relaxed forum and was well supported and the feedback was excellent. The research team attend patient groups and give talks about research opportunities at regular intervals and we have patient representation at our trial management and steering groups. The team are working hard with the Head of Volunteers to develop a role suitable for patients to promote research within the Trust. We also attend Trust induction to ensure all new staff are aware of the research department and the team and how they can get involved.

We are working hard with our colleagues in Musgrove Park Hospital and Somerset Partnership to run research studies that span the whole patient's journey within Somerset to enable them to access research at every opportunity. We also have developed close collaborative working with the Symphony Health Service GP practices in Somerset to ensure patients can access research that may cross secondary and primary care.

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. We are in the NIHR top ten small acute trusts league table recruiting into research and this is a great accomplishment for a small district general hospital and our patients and staff.

2.35 Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of Yeovil District Hospital income in 2018/19 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 2018/19 and for the following 12 month period is available electronically at https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf

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 Somerset Sustainability and Transformation Partnership (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 2018/19 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.
- Improving the uptake of flu vaccinations for frontline clinical staff within Providers.
- Reduction in antibiotic consumption per 1,000 admissions
- Personalised Care and Support Planning

2.36 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, £2,330,277 for 17/18 and the following for 2018/19:

Breakdown of Planned 1819 CQUIN:

NHSE - Military	£7,328
NHSE - Dental (half year only as service transferred)	£10,353
NHSE - Specialist Commissioning	£79,498
Somerset CCG	£1,927,569
Dorset CCG	£353,675
Total Planned CQUIN	**£2,378,423**

CQUIN for 18/19 has to be agreed with CCG and is discussed as part of the Contract Performance meetings.

The CQUIN achievement for 2018/19 has been fully achieved for Dorset and Somerset CCG's. NHSE specialised commissioning achievement is yet to be determined.

The CQUIN programme for 2018/19, 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.

2.37 Review of Our Services

During 2018/19 Yeovil District Hospital NHS Foundation Trust provided 43 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 85.6% of total income.

2.38 Registration and Compliance

Yeovil District Hospital is required to register with the Care Quality Commission and its current registration status is Requires Improvement, the Clinical Services review was graded Good overall.

Yeovil District Hospital has the following conditions on registrations – none.

The Care Quality Commission has not taken enforcement against Yeovil District Hospital during 2018/19.

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

CQC Service Ratings

Services ratings are described in the following tables:

2016 Inspection Summary

	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 series of improvement work was undertaken in response to the comprehensive inspection including focus on the following areas:

- 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.

2019 Inspection Summary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Outstanding ↑↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Medical care (including older people's care)	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Surgery	Requires improvement Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Critical care	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Maternity	Good Apr 2019	Good Apr 2019	Outstanding Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Services for children and young people	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
End of life care	Requires improvement ↓ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Outpatients	Good Jul 2016	N/A	Good Jul 2016	Good Jul 2016	Good Jul 2016	Good Jul 2016
Overall*	Requires improvement →← Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019

The most recent inspection was undertaken in December 2018 and January 2019. This is the first time we have been rated under new assessment criteria, which includes an assessment of our core clinical services (see table above) – undertaken by CQC – and a Use of Resources assessment – carried out by NHS Improvement. Both these ratings are amalgamated to provide a single, overall rating for the organisation.

We are pleased to report that our core clinical services have been rated as 'Good' overall. However, our 'Use of Resources' rating is 'Inadequate' which results in an overall rating for the Trust of 'Requires Improvement'.

The overall assessment of all core hospital services is 'Good' – the second best rating available from CQC – we are delighted that two of our services achieved the highest possible 'Outstanding' results in certain areas. See the table of results above. For our urgent and emergency services, which were previously rated as 'Requires Improvement' by the CQC, the rating of 'Good' across every element of this latest inspection is further enhanced by an assessment of 'Outstanding' for the responsiveness of their care. These excellent results were mirrored in our maternity services, which were previously rated as 'Requires Improvement' by the CQC, with 'Good' ratings across the board and an 'Outstanding' for caring.

The core clinical services report details significant improvement across all domains with areas for improvement focused on the safe domain. The Trust has committed improving nursing documentation to reflect risk assessments undertaken and appropriate care plans in place and will continue to work with our Children Social Care and CAMHS colleagues to provide a safe and appropriate care pathway for children and young people experiencing emotional health concerns.

In relation to the actions required for the Use of Resources report, in summary we are required to demonstrate better oversight of our financial Governance and develop more robust plans for addressing and reducing the elements of the deficit which are within our control.

The key areas identified as requiring improvement within the clinical core services include:

- Improve storage in some areas of confidential patient records.
- Ensure all mandatory training is meeting trust targets.
- Complete and escalate early warning scores appropriately.
- Check resuscitation equipment every day or as is required by trust policy.
- Maintain fully accurate records of patient care and complete fluid balance charts in line with trust policy. Complete resuscitation paperwork in line with trust policy and national guidance.
- Improve processes for mental capacity assessment and ensure documentation is completed in line with trust policy and national guidance.
- Include decisions about resuscitation and treatment escalation plans to ensure these are completed in line with trust policy and national guidance.
- Review processes for safe administration of medicines through a syringe driver, including infection prevention and control measures.
- Safeguard children and young people at all times by monitoring and assessment to reduce the risk from self-harm.
- Seek support to ensure there is good awareness of the opportunities to access and use benchmarking data to drive improvement.

The trust has developed a comprehensive action plan as a result of the report which was received on May 8th 2019 and this will further inform our Quality Priorities. This action plan is subject to review and monitoring via the Governance and Quality Assurance Committee to ensure progress is evident.

2.39 National and Contractual Quality Standards (See table below)

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	Aug17-Jan18	79.5	76.6	88.9	71.8	78.4	-
	Responsiveness to patients' needs	NHS Digital	Aug17-Jan18	69.1	66.3	85.0	60.5	68.6	-
	Staff Sickness	NHS Digital	Apr18-Mar19	3.4%	3.0%	2.4%	5.5%	4.0%	-
	Staff Turnover	Trust	Apr18-Mar19	15.6%	17.8%	-	-	-	-
	NHS Staff Survey Response rate	NHS Digital	Apr18-Mar19	71%	58.0%	72.0%	33.0%	45.0%	-
Effective	Palliative Care Coding	NHS Digital	Oct17-Sept18	53.2%	29.8%	58.6%	11.2%	33.6%	-
	SHMI	NHS Digital	Oct17-Sept18	100	96.2	72.7	1.25	100	100
	PROMS: Hip Replacement - EQ VAS	NHS Digital	Apr17-Mar18	*No Data*	71.9%	-	-	68.0%	-
	PROMS: Hip Replacement - EQ 5D Index	NHS Digital	Apr17-Mar18	*No Data*	90.2%	-	-	91.0%	-
	PROMS: Hip Replacement - Oxford Hip Score	NHS Digital	Apr17-Mar18	*No Data*	95.4%	-	-	98.0%	-
	PROMS: Knee Replacement - EQ VAS	NHS Digital	Apr17-Mar18	100.0%	48.7%	-	-	59.0%	-
	PROMS: Knee Replacement - EQ 5D Index	NHS Digital	Apr17-Mar18	100.0%	73.2%	-	-	83.0%	-
	PROMS: Knee Replacement - Oxford Knee Score	NHS Digital	Apr17-Mar18	100.0%	100.0%	-	-	94.0%	-
	Readmissions in 28days: 0-15yrs	NHS Digital	Apr18-Mar19	9.40%	8.40%	-	-	-	-
	Readmissions in 28days: 16yrs+	NHS Digital	Apr18-Mar20	9.30%	8.40%	-	-	-	-
Caring	MSA Breaches	NHS Digital	Apr18-Mar19	0	0	-	-	-	-
	Complaints rate	Trust	Apr18-Mar19	5.4	7.3	-	-	-	-
	Staff - Friends and Family Test	NHS Digital	2018	74.0%	68.0%	-	-	-	-
	Maternity - Friends and Family Test	NHS Digital	Apr18-Mar19	96.0%	94.8%	-	-	-	-
	Inpatients and Daycases - Friends and Family Test	NHS Digital	Apr18-Mar19	94.6%	94.0%	-	-	-	-
	Emergency Dept - Friends and Family Test	NHS Digital	Apr18-Mar19	94.0%	92.6%	-	-	-	-
Safe	VTE Risk Assessment	NHS Digital	Apr18-Mar19	94.4%	92.1%	100.0%	54.9%	95.7%	95.0%
	Safety alerts	NHS Digital	Apr18-Mar19	0	0	-	-	-	-
	Never Events	NHS Digital	Apr18-Mar19	0	1	-	-	-	-
	Emergency C -Section Rates	Trust	Apr18-Mar19	15.8%	17.5%	-	-	16.0%	-
	Rate of C.difficile infection per 100,000 beddays	NHS Digital	Apr18-Mar19	4.9	7.8	-	-	12.1	-
	MRSA bacteraemias	NHS Digital	Apr18-Mar19	0	0	-	-	0.8	-
	Rate per 1000 bed days - Patient safety incidents	Trust	Apr18-Mar19	43.2	41	-	-	-	-
	Percentage of Patient Safety Incidents that resulted in severe harm or death.	Trust	Apr18-Mar19	0.082%	0.019%	-	-	-	-
Risk Assessment Framework Indicators	Clostridium (C.) difficile – meeting the C. difficile objective (All)	NHS Digital	Apr18-Mar19	5	4	-	-	-	-
	Certification against compliance with requirements regarding access to health care for people with a learning disability	Trust Board Declaration	Apr18-Mar19	Compliant	Compliant	-	-	-	-
	62 day wait for first treatment from urgent GP referral: all cancers	CWT RETURN	Apr18-Feb19	80.0%	83.8%	-	-	-	85.0%
	62 day wait for first treatment from consultant screening service referral: all cancers	CWT RETURN	Apr18-Feb19	83.1%	94.4%	-	-	-	90.0%
	31 day wait from diagnosis to first treatment: all cancers	CWT RETURN	Apr18-Feb19	97.5%	97.8%	-	-	-	96.0%
	31 day wait for second or subsequent treatment: surgery	CWT RETURN	Apr18-Feb19	94.6%	95.6%	-	-	-	94.0%
	31 day wait for second or subsequent treatment: anti cancer drug	CWT RETURN	Apr18-Feb19	97.6%	100.0%	-	-	-	98.0%
	Two week wait from referrals to date first seen: all cancers	CWT RETURN	Apr18-Feb19	91.7%	95.2%	-	-	-	93.0%
	Two week wait from referrals to date first seen: breast symptoms	CWT RETURN	Apr18-Feb19	93.7%	95.2%	-	-	-	93.0%
	18 week maximum wait from point of referral to treatment (incomplete pathways)	UNIFY RETURN	Apr18-Mar19	90.5%	93.3%	-	-	-	92.0%
	Maximum 6-week wait for diagnostic procedures	WEEKLY SITREP	Apr18-Mar19	99.7%	99.0%	-	-	-	99.0%
	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	WEEKLY SITREP	Apr18-Mar19	97.3%	96.9%	-	-	-	95.0%

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

- SHMI has remained within the expected range

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

- Share indicator and expected range with the Board
- Monitor at the Clinical Outcomes Committee
- Triangulate with HSMR at Clinical Outcomes Committee
- Move to utilising Dr Foster data

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

In 2018 there was a decision to move to amplitude as the PROMS provider - this provides an electronic version of the PROMs data collection but is not restricted to the mandatory requirements of Hips and knees. The data for PROMS was not available for a 6 month period as there were issues with the data interface. These issues are now resolved and we are now collecting all PROMS data for Trauma and Orthopaedics as required.

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 and use of the Somerset Treatment Escalation Plan
- 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
- Introduction of a new End of Life Care Plan

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
- Re-establishment of a VTE Working Group
- Review and update of Trust policy in line with NICE guidance
- Weekly monitoring of performance

Yeovil District Hospital considers that C diff data is as 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
- Rapid isolation of suspected cases

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

- Increased focus on improving rates of reporting to determine risks without harm, thus allowing for earlier mitigation
- Implementation of NEWS2, digital capture of patient vital signs, review of Deteriorating Patient policy
- Increased suite of simulation training modules in relation to deterioration

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 from the incident reporting system to provide assurance of actions taken

The auditors carried out work on two mandated indicators, specified by NHSI in its guidance.

- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

The auditor has verified that our work on the two mandated indicators has concluded that there is sufficient evidence to provide a limited assurance opinion in respect of maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers and percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

The Trust continues to take the following actions to validate this position:

- Implementation of ERS has reduced the number of errors on clock start dates. For those areas which do not have electronic referrals and there is a manual process, the validators review and check the correct dates are entered.
- Monthly Audit in place to audit sample areas for clock stops. This is reviewed by the RTT group and training/correction is addressed.

In addition and during the transfer of our Oral Max Fax service to another local provider, the RTT pathway accuracy was audited by an external party who was satisfied that the Trust had utilised the RTT recording guidance appropriately.

2.40 Data Quality

An external clinical coding audit was undertaken by NHS Digital Approved Clinical Coding Auditors) on behalf of YDH which examined the clinical coding accuracy of 199 spells (200 FCEs) for activity between Nov 1st 2018 and 11th Jan 2019. The areas

reviewed were known high activity areas for the trust including: Trauma & Orthopaedic, geriatric medicine and a random sample of 1+ Length of Stay (LoS). This audit will also be used to satisfy the clinical coding audit needs of the Data Security and Protection Toolkit.

Table 1: Summary findings from the audit (Provisional)

Area	Spells tested	Pre-audit value	Post-audit value	Net change	Net change
Overall	199	£376,511	£378,506	£1995	0.53%

The error rate resulted in a potential net financial undercharge of £1995 to the commissioners for the sample audited. The coding accuracy achieved the mandatory Data Security and Protection Toolkit level overall with both secondary diagnoses and secondary procedures reaching the higher advisory levels.

Table 2: Data Security and Protection Toolkit levels of attainment (Provisional)

Acute Trust	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
Advisory	>=95.0%	>=90.0%	>=95.0%	>=90.0%
Mandatory	>=90.0%	>=80.0%	>=90.0%	>=80.0%
Yeovil	94.00%	95.81%	93.68%	93.01%

The hospital accuracy levels are only 1% and 1.32% for primary diagnoses and primary procedures respectively off of achieving the highest advisory attainment level. Compared to the 2017/18 audit this has highlighted an improvement in both of these areas with primary diagnosis accuracy increasing by 2.63% and primary procedure accuracy increasing by 1.75%. The secondary diagnosis accuracy has also improved from 2017/18 increasing by 7.34% to now reach the advisory level. The secondary procedure accuracy has fallen from 2017/18 by 1.91% but still meets the advisory level.

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/scheduled in a timely manner as per each audit's action plan.

The completion of clinical coding remains at 99%+ coded by day 3 which has historically been highlighted as a potential cause of the increased error rate in diagnostic coding. As a result of this the department recruited for a further qualified coder to help maintain coding turnaround timeframes whilst improving accuracy who was appointed to post in Apr 2018. In part this new position has helped evidence an increase in accuracy in three of four areas.

The action plan from the 2017/18 audits has proved successful showing a significant improvement in the secondary diagnosis accuracy in part due to the additional post and regular internal audit highlighting and addressing issues as they arise.

2.41 Payment by Results (PbR) Audit 2018/19

Yeovil District Hospital NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Yeovil District Hospital submitted records during 2018/19 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:

- 99.8% 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:

- 99.4% for admitted patient care;
- 98.2% for outpatient care;
- 99.4% for Accident and Emergency Care.

2.42 Information Governance

Yeovil District Hospital Information Governance Assessment Report overall score for 2017/18 (version 14.1) was 77% and was graded Green – Satisfactory.

In March 2018 NHS Digital released the Data Security & Protection Toolkit (DS&P) replacing the Information Governance Toolkit (IGT), lending itself to a more digital world and addressing standards laid down by the National Data Guardian's (NDG) review published in 2016.

We are continuing to work on the DS&P Toolkit and will make our final submission 31 March 2019 for year 2018/19

On 25 May 2018 General Data Protection Regulations (GDPR) were released. With guidance from the Information Commissioners Office we have undertaken the following work.

- Reviewed and updated our Information Governance training,
- Reviewed all contracts to establish the lawful basis for processing personal information.
- Updated Privacy Notices for patients and staff
- Created a data base to record any data subjects exercising the right to stop processing their data
- Meeting Subject Access Requests within 1 month with no charges made.
- Reporting incidents via the DS&P matrix within 72 hours and following further investigation processes where required.
- Implementing a Data Protection Impact Assessment (DPIA) Policy to support the review of new processes and technologies
- Appointed a Data Protection Officer
- Reviewed working practices to ensure lawful international transfers

We continue with this 'work in progress' to ensure we meet GDPR/DPA standards and compliance

3. Other Information

3.1 Patient Safety and Quality Improvement

The Trust demonstrates its ongoing commitment to Patient Safety and continues to participate in the South West Academic Health Science Network (AHSN) events to support the National Patient Safety Collaborative.

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. This 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 Patient 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, Sepsis);
- Pressure Ulcer Steering Group;
- Falls Prevention Group;
- Maternity Safety

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

3.2 Patient Safety Incidents

There were 8,295 incidents reported in 2018/19, this is a 5.6% increase from the number of incidents reported in 2017/18 (7,855). Of these, 4,795 were patient safety incidents.

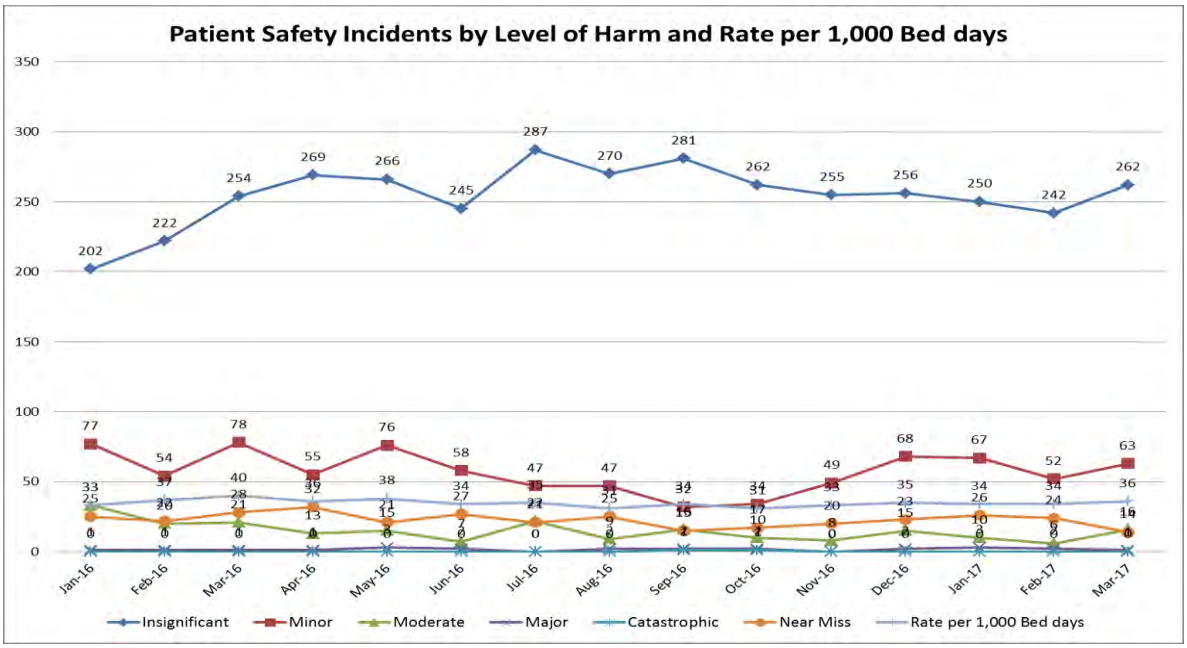
Of the 4,795 patient safety incidents, and in line with national guidance, 340 were classed as a near miss, 3,675 were no harm, 634 were no harm, 137 were moderate harm, 9 severe harm and one death.

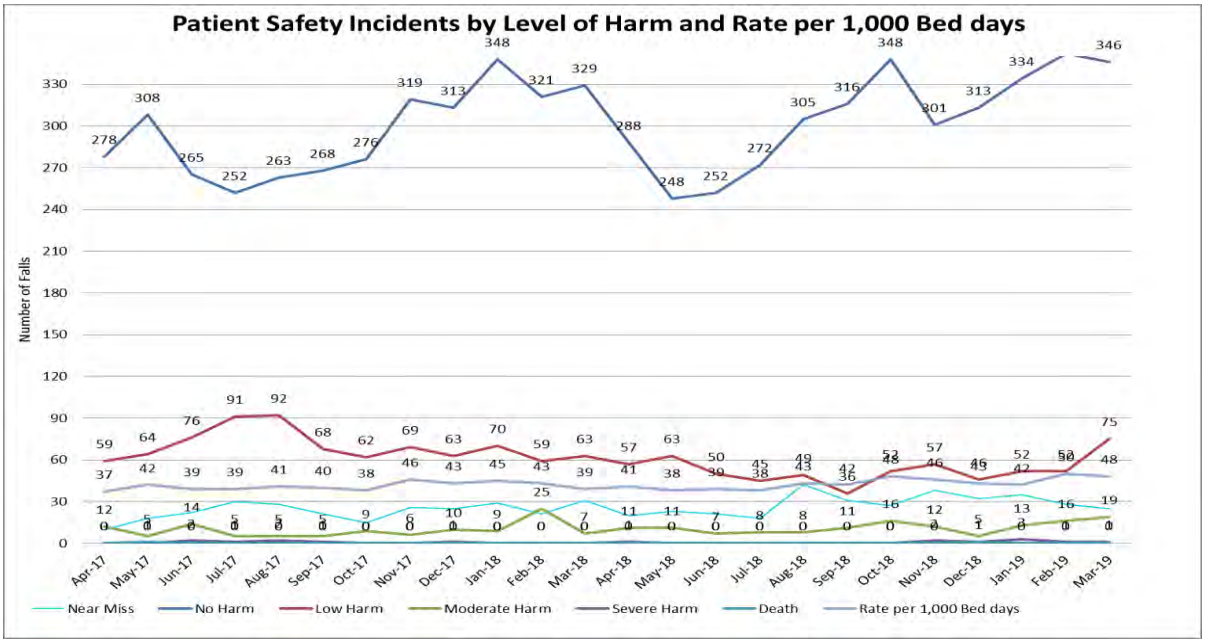
The Trust routinely reports all patient safety incidents to the National Reporting and Learning System (NRLS) and adheres to the national policy on incident reporting and investigation. Overall the Trust has seen a rise in incident reporting, demonstrating improvement in safety culture and a reduction 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. However, during the year, the frequency of incident reporting has decreased by 1.9%. Changes have been made to the electronic incident reporting system in response to staff feedback, this position will be monitored by the Patient Safety Committee.

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.

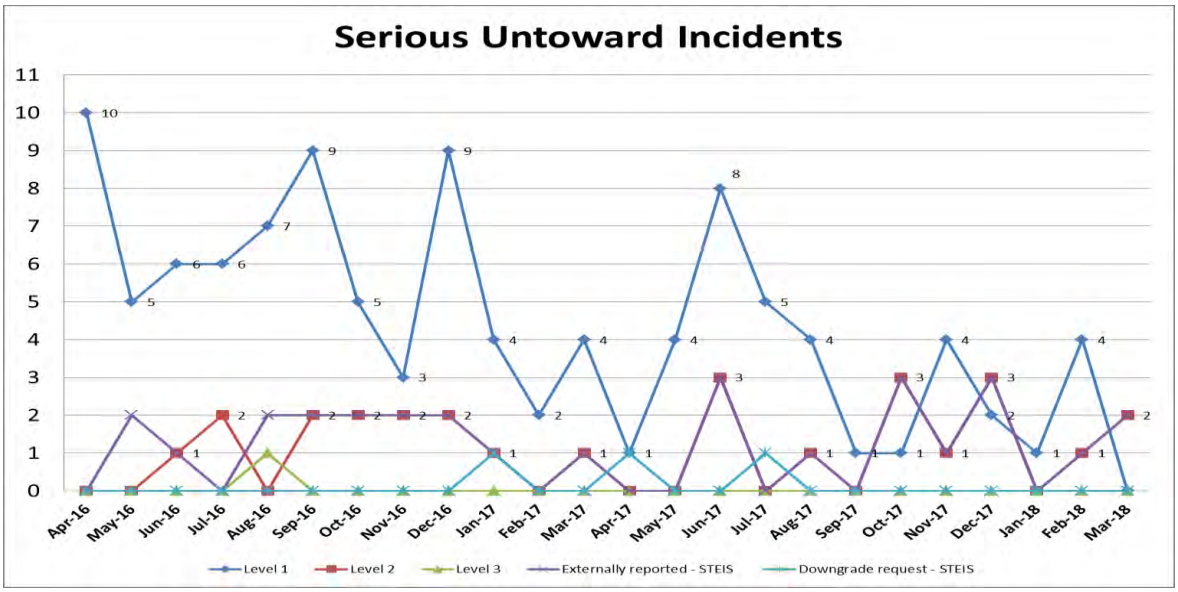
The following chart shows the Patient Safety incident data for 2018/19 and shows the different levels of harm reported.





3.3 Serious Incidents

A total of 35 investigations were commissioned in 2018/2019. Of these, 10 required a Comprehensive Root Cause Analysis (Level 2 investigation) and 10 met the definitions of a Serious Incident Requiring Investigation, in accordance with national definitions and guidance, and were reported to Somerset Clinical Commissioning Group. 9 Serious Incidents met the threshold for Duty of Candour which was complied with accordingly.



3.4 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.

Duty of Candour (DoC)	Apr 18	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Number of incidents requiring first DoC (statutory requirement to write to patient/next of kin within 10 working days of notification of incident)	1	5	4	1	5	1	5	3	1	6	0	4
Compliance with first DoC (statutory requirement to write to patient/next of kin within 10 working days of notification of incident)	0	5 100 %	4 100 %	1 100 %	2 40 %	1 100 %	5 100 %	3 100 %	1 100 %	6 100 %	0	4 100 %
Number of investigations Quality Assured/Signed Off	1	0	5	8	6	0	6	1	2	4	4	0
Number of incidents requiring second DoC (statutory requirement to write to patient/next of kin within 10 working days of completion of report)	0	0	5 100 %	6 80%	5 80 %	0	3 50%	1 100 %	2 100 %	0	2 100 %	0
Compliance with second DoC (statutory requirement to write to patient/next of kin within 10 working days of completion of report)	0	0	5 100 %	6 100 %	3 60 %	0	3 100 %	1 100 %	2 100 %	0	2 100 %	0

3.5 Learning into actions

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:

Never Event Peripherally inserted central catheter (**PICC) line- Incident took place 2017/18**

- PICC care training available for all nurses on a twice monthly basis, as well as the facility to undertake ward base training.
- Who Surgical Check list has been amended to include CVP lines, dialysis lines and PICC lines.
- Sherlock insertion system to be used with all PICC line insertions.

Information Governance raised through incidents resulting in SI

- Maternity service has changed a number of practices to ensure information is protected. This includes ensuring outpatient notes are kept within a locked trolley.

Patient Safety Alerts through NHS Improvement Alerts

- Teaching regarding the use of SI incident reporting system and highlighting high level of reporting in organisations is usually linked with low levels of harm how to use the system and recent patient safety alerts that have relevance Trust Wide.
- Collaborative working with Primary care and secondary care to ensure patient have bowel management

NEWS 2 introduction into the Trust to help identify deteriorating patients

- NEWS 2 has been rolled out across the Trust with our updated VitalPac system, we are still using paper copes in the Emergency Department, Theatre and Ward 10.
- On-line training has been provided for all clinical members of staff to provide the introduction of this update to assist with identifying and recusing deteriorating patients.

Review multidisciplinary risk assessments for younger people presenting in ED with mental health issues raised through SI

- Clear Joint CAMHS, YDH and Children's Social Care management plan required for all patients to include, level of supervision required, proportionate restraint procedures and behaviour contracts with patients and carers
- Improved knowledge of policies and procedures such as ligature risk management, patient observation, deliberate self harm protocol and joint complex patient protocol
- Additional training and support/supervision for all staff managing young patients with increased and unpredictable risks in an acute settings, to include de-escalation and therapeutic interventions

Learning from Deaths

- Positive impact of active and timely discussion with patients and their families on treatment escalation and resuscitation status.

3.6 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 94.8%. This is an increase on 17/18 data due to the work that has been undertaken following the change in electronic data capture with the implementation of Trakcare. Q3 and Q4 17/18 did meet the 95% target and work is continuing to ensure this level of performance is maintained.

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.

3.7 Maternity Safety

Birth numbers are slightly down this year to 1405. Compared to the financial year 17/18 this represents a 5% drop in birth numbers. Whilst the regional dashboard data for 2018/19 is not yet available, data for other parts of Somerset suggests that elsewhere in the county the decrease is more marked than at YDH which is suggestive of a normal and expected fluctuation in birth rate.

The home birth team continues to be very successful with an overall rate of 5.6%. Work has now commenced on further strengthening and developing the midwife led pathway as we move towards opening our alongside midwifery led unit which will further increase the percentage of “out of hospital” births.

The service works to the Saving Babies lives care bundle which includes action around the monitoring of small for gestational age babies – the (GAP/Grow programme). Staff have undergone advanced training and an annual perinatal institute funded study day is provided to ensure that all staff assessing fetal growth during pregnancy have had the appropriate level training. Governance structures around this issue have been strengthened with the establishment of a GAP working party – a new policy has been written and all cases are incident reported with a missed case rolling audit to identify learning. Intrauterine growth retardation is associated with smoking in pregnancy and the number of women who continue to smoke at delivery (11.6%) remains equal to those smoking at booking (11.6%). This suggests that women who smoke at booking continue to do so throughout their pregnancy. Smoking cessation services are offered on an opt out basis to smokers. Data suggests that 82% are offered carbon monoxide monitoring at booking and 79.9% taking up this offer, but it has recently been found that women who have miscarried in early pregnancy are included in the denominator data. This has now been rectified. There is therefore a lot of preventative work including an increased focus

on public health measures taking place and innovative approaches to reaching those most at risk in order to reduce the number of small for gestational age babies, however, demographic issues continue to provide a challenge to achieving a sustainable decrease in low birthweight babies.

The caesarean section has remained stable since last year with just a 0.3% decrease. A recent review has found that there were an increased number of caesarean sections where maternal choice was at least one of the indicators. There has been recent professional debate over the fact that maternal request for Caesarean section is accepted by NICE guidance to be an indication providing that the woman is fully informed of the risks and benefits. If it is the woman's choice to opt for caesarean section and she has given full and informed consent it is difficult to argue that her choice should not be met. On a positive note there has been a 2.4% decrease in the rate of emergency caesarean sections.

Other clinical areas of concern are our ongoing post-partum haemorrhage rate which had made an initial improvement but has slipped again. Measures recently undertaken to readily identify excessive bleeding include scales in the labour rooms to weigh swabs etc. to get an even more accurate measurement of blood loss and plans to introduce a new method of risk assessment in the form of an obstetric bleeding strategy.
The rate of third and fourth degree tears following normal deliveries has steadily increased throughout the year. The underlying cause of this could be multi-faceted. Episiotomy rates, birth positions, water birth and a "hands off" approach during birth can all be contributory factors. A multi-disciplinary task and finish group is to be established to work on a reduction strategy including the introduction of episiotomy skills in the preceptorship package, encouraging midwives to develop episiotomy skills by undertaking them under the direction of a doctor when an instrumental delivery is about to be performed and a senior second midwife in the room at delivery to support if an episiotomy should be required. A reflective practice form is to be introduced to be completed by any practitioner who conducts a delivery which results in a 3rd and 4th degree tear.

Year to date rates are showing an encouraging downturn in neonatal morbidity and mortality a total of 4 still births and 1 neonatal death. This compares favourably with 2017/18 when there were 7 stillbirths and 2 neonatal deaths. Of the stillbirths this year, one was due to a cord prolapse at home and the other three were intrauterine deaths prior to onset of labour. One of these cases has been reviewed using the perinatal mortality review tool. There were no issues or concerns with the antenatal care provision. The panel is yet to sit and review the other two cases (1071 births in quarters 1-3 the stillbirth rate is 0.28% which is better than the current national average of 0.41%.

3.8 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

All published audit reports are reviewed by the clinical teams and the publication date is reported to the Clinical Outcomes Committee. The reports of 30 national clinical audits were reviewed by the provider in 2018/19 and Yeovil District Hospital intends to take the following actions to improve the quality of healthcare provided.

3.9 National Paediatric Diabetes Audit (NPDA) – Royal College of Paediatrics and Child Health

The aim of this audit is to improve the care, outcomes and experiences of children and young people with all types of diabetes treated within NHS Paediatric Diabetes Units (PDU) until the age of 24 years.
The audit highlighted 68.85% young people, aged 12 years and older, in Yeovil District Hospital received all seven care processes between April 2016 and March 2017 compared to 43.5% across England and Wales. (48% young people, aged 12 years and older, in Yeovil District Hospital received all seven care processes between April 2015 and March 2016 compared to 35.5% across England and Wales). It is not possible to make direct comparison rates of the seven care processes reported before April 2015 as this was the first time the audit presented the information for children and young people with Type 1 diabetes only.

Action Plan:

- Online data submission is now available in clinics to improve complete data collection
- A business case to recruit a designated clinical psychologist for Yeovil District Hospital has been approved to improve access and supervision
- To improve education regarding eye screening and kidney screening
- To ensure all eye screening results are included in the audit
- To improve urine screening and ensure all results are included in the audit

3.10 Royal College of Emergency Medicine Audits (RCEM)–Royal College of Emergency Medicine

The aim of these audits is to identify current performance in Emergency Department against RCEM clinical standards, show the results in comparison with other departments and also across time if there was previous participation.

Procedural Sedation in Adults audit
The four fundamental standards were not met up to the national average:

- Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status (2017/18 – 0%, 2015/16 - 0%)

- Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities (2017/18 – 30%, 2015/16 - 55%)

- Procedural sedation requires the presence of all of the below a) a doctor as sedationist, b) a second doctor, ENP or ANP as procedurist, c) a nurse (2017/18 – 30%, 2015/16 - 9%)

- Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG (2017/18 – 6%, 2015/16 - 12%)

Action Plan:

- Sedation proforma amended and made into a single proforma with clear guidance
- Safety checklist introduced
- Introduce an ED sedation kit box (containing drugs and equipment, sedation proforma and safety checklist)

3.11 National Audit of Care at the End of Life (NACEL) – NHS Benchmarking Network

The aim of this audit is to assess the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. (This is the first audit round. The second round of the audit will take place in 2019 and will again include an organisational level audit, case note review and the NACEL Quality Survey).
The audit highlighted three areas where the Trust performed below the national average:

1. Communication with families and others
2. Individual plan of care
3. Workforce / specialist palliative care provision

These areas had been identified as points of concern prior to this audit and the following actions are in place:

- Development of a new end of life care plan – rolled out across the trust from January 2018, addressing points 1 and 2
- Development of a programme to look at 7 day working for palliative care– addressing point 3
- Development of a communication skills programme for all staff – addressing point 1

Patient Experience

3.12 National Inpatients Survey 2018

The findings from the 2018 Inpatient Survey were received from the Picker Institute in February 2019.

This annual survey asks the views of adults who had stayed at least one night as an inpatient during the month of July 2018. 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. 1,199 were eligible for the survey, of which 627 returned a completed questionnaire, giving a response rate of 52%.

The 2018 survey has highlighted the many positive aspects of the patient experience, including:

- Admission: did not have to wait long time to get to bed on ward which saw a 5% improvement;
- Hospital: not bothered by noise at night from other patients saw a 6% improvement;
- Discharge: was not delayed saw a 5% improvement;
- Hospital: not bothered by noise at night from staff saw a 4% improvement;
- Hospital: got enough help from staff at mealtimes saw a 4% improvement.

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:

- Admission; did not have to wait long time to get to bed on ward;
- Hospital: not bothered by noise at night from staff;
- Hospital: food was very good or good;
- Hospital: offered a choice of food;
- Hospital: got enough to drink;
- Care: staff helped control pain;
- Care: staff helped within reasonable time when needed attention.

However, the Trust is below the national average in several areas' relating to patient experience:

	Average %	YDH %
Planned admission date not changed by hospital	79	70
Hospital: staff completely explained reasons for changing wards at night	81	72
Nurses: did not always know which nurse was in charge of care	81	77
Care: right amount of information given on condition or treatment	80	76
Procedure: told how to expect to feel after operation or procedure	88	84
Discharge: patients given written/printed information about what they should or should not do after leaving hospital	63	56
Discharge: told purpose of medication	91	88
Discharge: given clear written/printed information about medicines	85	78
Discharge: told of danger signals to look for	64	58
Discharge: family given enough information to help care	76	70
Discharge: told who to contact if worried.	79	70

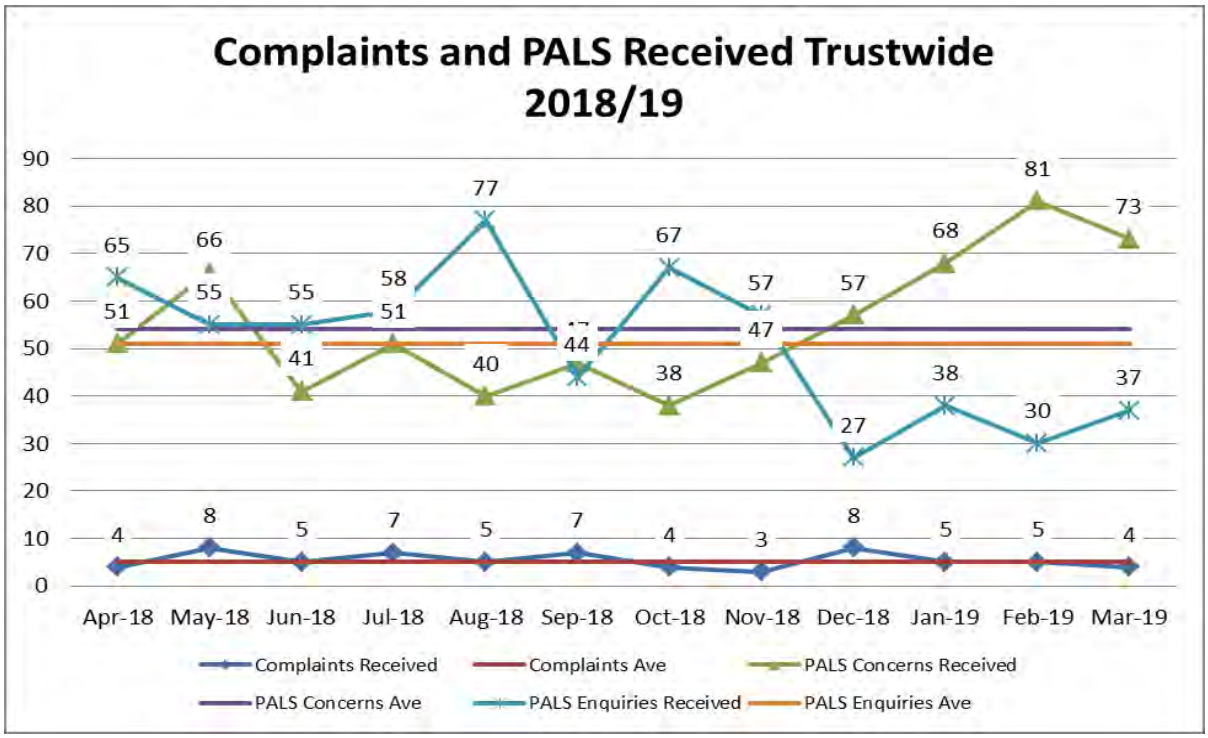
The Trust is aware of the improvement needed from the results of the survey and will be working closely with the patient experience team, nursing staff, doctors and business managers to ensure improvements are made in these key areas. This will be monitored by the Patient Experience and Engagement Steering Group.

3.13 Patient Feedback, Complaints

During the year, both the Complaints and PALS teams have further developed their processes to ensure a robust management of formal complaints, PALS enquiries and concerns. The process now includes an early intervention contact, where expected outcomes are discussed and agreed prior to commencing any investigations or reviews.

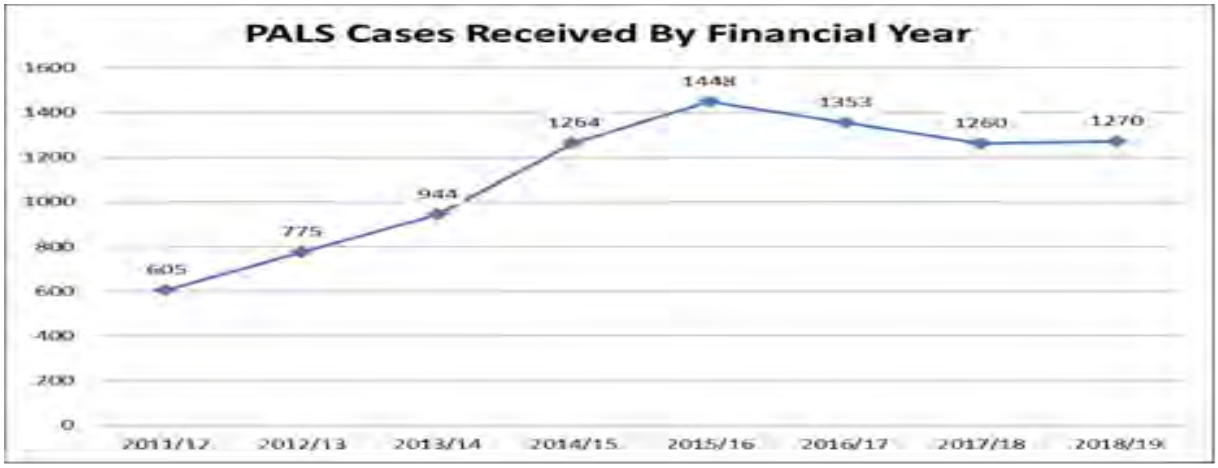
All complaint response letters now also include whether the complaint has been upheld, partially upheld or not upheld. Where appropriate, formal complaints responses include an action plan to address issues identified during our investigations, the actions are implemented by senior members of staff and taken to the departmental peer reviews and to the Patient Experience and Engagement Steering Group.

Complaints and PALS concerns and enquiries are outlined in the graph below:



3.14 Patient Advice and Liaison Service

The PALS service received 333 PALS concerns/enquiries during the first quarter and 317 during quarter 2, 293 during quarter 3, and 327 during quarter 4.



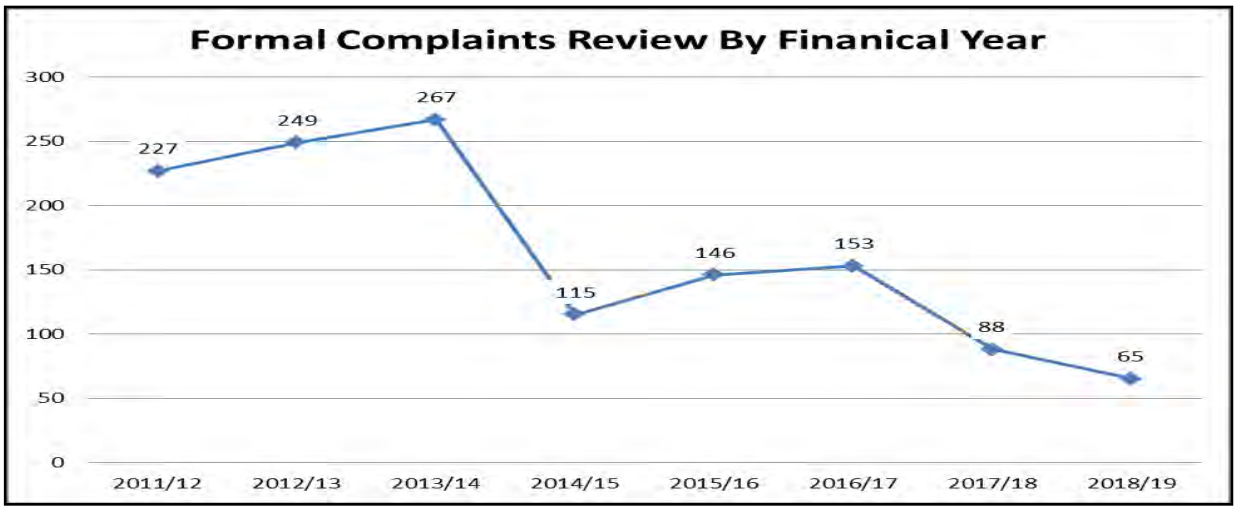
Whilst previously, conciliation meetings were largely conducted as a result of a formal complaint process, a significant number of conciliation meetings now occur as a result of

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, it is recognised that this is more effective in terms of resolving concerns as early as possible.

All PALS contacts are graded as either an enquiry (easily and quickly resolved) or a concern (which needs an investigation), Departmental Managers make initial contact with enquirers, where appropriate, and the PALS team now provide verbal or email responses to concerns unless specifically requested to be more formally in a letter. The last quarter has seen a significant increase in concerns compared to enquiries as shown in the above
Graph. The Patient Experience and Engagement Steering Group will review any factors relating to this and monitor any actions required.

3.15 Formal Complaints

There were 17 formal complaints received during Quarter 1, 19 during Quarter 2, 15 during Quarter 3, and 14 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. 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. The mandatory KO41 health and social care data return reported 89 compliant cases throughout 2017/18 and 65 for 2018/19.

The Head of Clinical Governance and Assurance and the Medical Director play a key role in conciliation and early intervention meetings which has made them very effective and provides opportunities for shared learning across departments and at Trustwide level. . Clinical input is also enormously beneficial and valued by complainants attending such meetings.

3.16 Actions agreed from Complaints

- Review content of patient information leaflet with regard to risks of Transobturator Tape procedure and expectation of any anatomical changes following procedure at Gynaecology Governance Meeting.
- Update the maternity booking pack to inform women that they will be asked for their relevant medical history when they ring the Labour Ward.
- When time specific medication is required in specific month and a outpatient clinic slot is not available, staff must escalate this to the Patient Services Manager or Operational Support Manager.
- Ward sister to work with the therapy team to trial new falls alarms system and audit effectiveness.
- Matron to arrange additional training for nursing staff on; the correct application and management of brace to support upper arm fracture.
- Tissue Viability Team to provide additional training in wound care and include documentation in new staff induction programme.
- Enhanced End of Life training programme (since Autumn 2018) being rolled out Trust wide to include; holding difficult conversations.
- Reiterate the need for staff to follow up with the Radiology Department to clarify any likely delay and reasons - inform patient and relatives and document in records.
- An appropriate care plan to be put in place should a particular patient be readmitted, ensuring there is a multidisciplinary approach taking into consideration her physical and mental health needs.

3.17 Patient Feedback Indicators / Patient Surveys

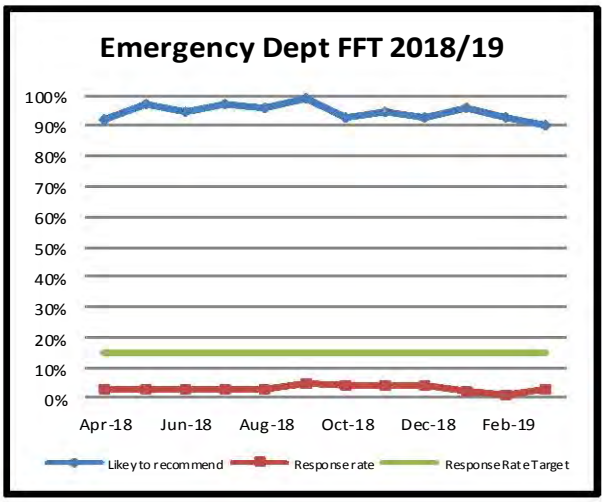
Patient Voice is a voluntary group which supports the organisation with obtaining feedback, often using observational audit. The group have a yearly schedule to survey patients on key subject areas. During the beginning of the year, the focus was relating to basic care which involved observations of the environment and key factors in care such as communication, being able to reach call bells and drinks, noise and cleanliness on the wards. The findings are discussed at the monthly Patient Voice meeting and at ward peer reviews to aid any learning or necessary changes, a report is also provided to the Patient Experience and Engagement Steering Group.

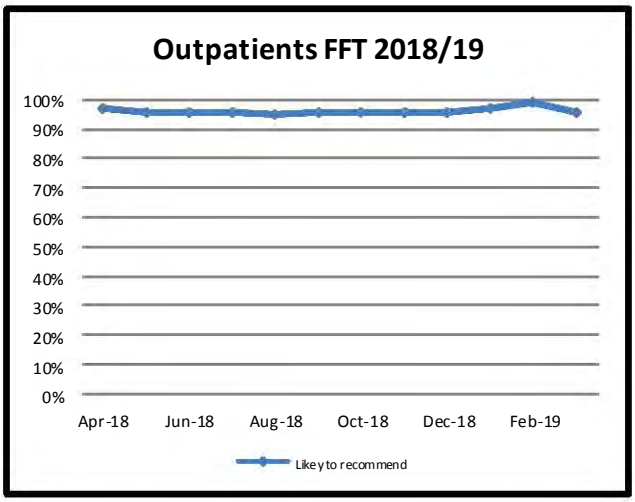
3.18 Friends and Family Test

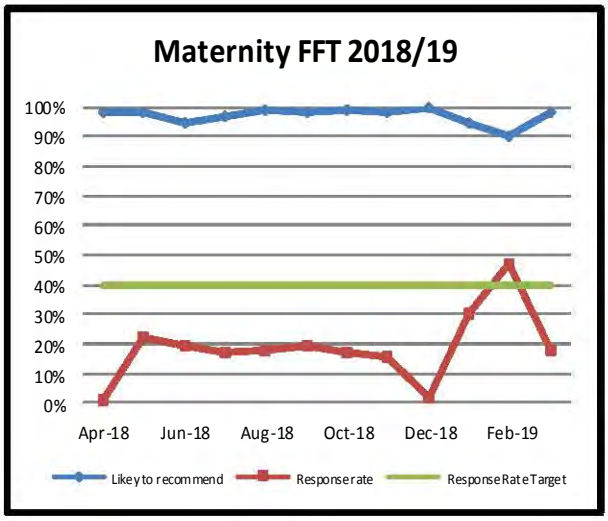
The Friends and Family Test (FFT) is collected from the inpatient wards, emergency department, maternity unit and outpatient clinics for national submission each month. 10,130 responses were collected throughout the year.

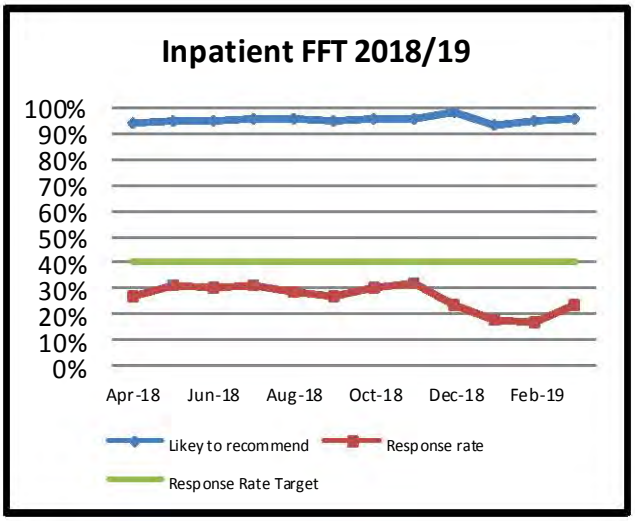
During March 2019, the survey was tested in house on one ward, and managed via the SNAP survey software. This trial was successful; therefore the survey will be managed completely in house as of April 2019, with a focus on encouraging and improving feedback from our patients so that we can make any necessary changes. Business cards have been developed allowing patients to complete the survey when they return home, volunteers have agreed to help by handing these out when they are present on the wards. Posters have been developed advertising the survey so that patients are encouraged to leave any feedback.

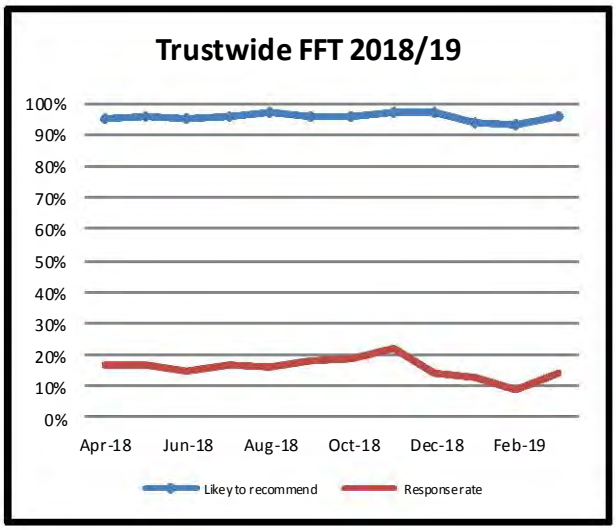
The following charts show the responses to the friends and family test for each area of submission (Emergency Department, Inpatient Wards, Maternity and Outpatient Clinics)

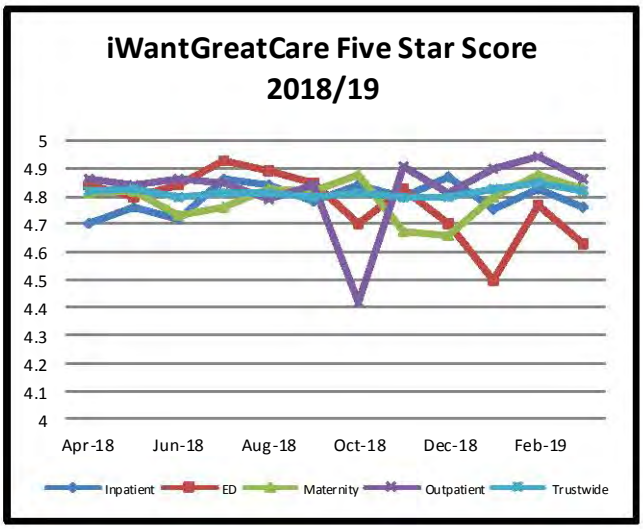












The other questions included in the Iwantgreatcare survey look at whether the patients felt they were treated with dignity and respect and felt involved enough in decisions made about their care, whether they received timely information about their care and treatment, whether the hospital was clean and 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 were identified that aligned with the Quality Priorities for 2018/19. These included:

- Publication of a Patient and Public Engagement Strategy
- Increase the percentage response rate for the Friends and Family Test – we had experienced a 1.8% decrease. By bringing this survey process back into the organisation we will be able to focus on encouraging and improving feedback from our patients so that we can make any necessary changes. In addition to increasing numbers of responses, we will focus on supporting patients to given honest feedback.
- We have worked collaboratively with Somerset Clinical Commissioning Group, Somerset Local Authority, Taunton and Somerset and Somerset Partnership NHS Foundation Trusts to host the first Always event nationally focused on system improvements. The event saw 50 attendees inclduing patients, carers, volunatry agencies and health and social care staff to consider what a good discharge from hospital (Acute, Community and Mental Health) should always look like. This has generated a number of patient-centred improvement projects and a countywide steering group has been established to provide oversight.

This programme of improvement work will take place throughout 2019/20 with oversight provided by the Yeovil District Hospital NHS Foundation Trust Patient Experience and Engagement Committee. Board level assurance will be via the Governance and Quality Assurance Committee.

3.19 Freedom to Speak up

The following table identifies the concerns that have been raised via the Freedom to Speak up Guardians. Staff can raise concerns either face to face, by email or on the Trust intranet. This gives them the opportunity to raise a concern anonymously if preferred. The Guardians also hold a weekly drop in session.

Feedback and outcomes are given directly to staff who make themselves known. If a concern is raised anonymously, where possible, and when appropriate, the outcome and improvements made as a result are published in the Trust news bulletin.

Guardians support staff and due to the open culture, no staff who have raised a concern have suffered as a result. Guardians are very happy to attend meetings with staff if that is required. This has resulted in a positive outcome on a number of occasions.

April 2018 to present	Nature of concern	Raised by	Outcome
1	Non-functioning equipment	Nurse	Matron confirmed that a replacement had been ordered.
2	Inappropriate conversations taking place in lifts	Anonymously	Reminder included in Trust wide news bulletin
3	Incorrect adherence to uniform policy	Anonymously	Staff involved were reminded
4	Incorrect process of admitting a patient	Patient's wife who is also a staff member	Procedure was clarified with the team involved.
5	Alleged bullying	Pharmacy assistant	Department dealt with this in line with Trust policy.
6	Unacceptable culture within a clinical team	Medical staff	Lengthy investigation with action plan in place as a result
7	Lack of cutlery available at ward level	Nursing staff	Additional supplies provided in an ongoing way.
8,9 and 10	Change of annual leave entitlement	Clerical staff	Handed over to Human Resources who provided an explanation
11.	Non-adherence to No smoking Policy	Nursing staff	Reminder of the importance included in Trust wide news bulletin
12	Difficulty in obtaining correct fillings for jacket potatoes at ward level	Anonymously	An improvement in the system was communicated via the Trust wide news bulletin
12	Poor care and alleged discrimination of staff	Nursing staff	Meeting with staff member and Matron to resolve these issues
13	Non-adherence to No smoking Policy	Nursing staff	Second reminder of the importance included in Trust wide news bulletin
14	Possible misuse of Trust funds	Anonymously	Director of Nursing provided a response
15	Discrimination and lack of support within a team	Nursing staff	Currently ongoing
16	Lack of support	Nursing staff	Currently on going

3.20 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 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

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 2018/19* ('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 Guidance.

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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, May 2019;
- feedback from governors, May 2019;
- feedback from local Healthwatch organisations, May 2019;

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey, February 2019;
- the national staff survey, December 2018;
- Care Quality Commission Inspection, December 2018;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated April 2019; and
- any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of 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 2019, 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.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the 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
28 May 2019

Annex 1 - Statement from the Council of Governors

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. Governor observers attend the Governance and Quality Assurance Committee, the Risk Assurance Committee and Patient Experience and Engagement Group. Governors are also invited to attend the full Board of Directors meeting on a rotational basis and are welcome to attend all Part 1 Board of Directors. At all these meetings, representatives are actively encouraged to participate and contribute their views, and to 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.

Once again, Yeovil District Hospital has achieved high performance of key standards, particularly with regard to four-hour waits and referral to treatment times – this has placed the Trust amongst the best performing trusts in the country.

Yeovil District Hospital worked towards achieving the priorities set for 2018/19, with focus on:

- safety and quality of patient experience, including maternity and patients with dementia
- safer care which reduces avoidable harm
- learning from deaths
- mental health
- staff retention and wellbeing

Work towards improvement has involved the inclusion of staff, patients and carers in identifying areas to develop and in finding solutions. The introduction of TagCare has led to a reduction in harm to patients at high risk, there have been no 'never events' reported, infection control figures have continued to improve compared to previous years and to other organisations. The Governors are encouraged to note that the Trust continues to maintain high Safety Thermometer results, with an overall average of 98% of patients being recorded as harm free.

The Council of Governors acknowledge the recent report from CQC. Governors are delighted to see the improvements in judgements across so many areas of the hospital, in particular the outstanding results for Urgent and emergency care and for Maternity. Governors would like to congratulate all the staff involved in achieving these outcomes, of which they should be very proud and which mean that the overall assessment for core services is 'Good'. The overall rating for the Trust of 'Requires Improvement' is disappointing but Governors are aware of the financial pressures under which the Trust is working and the plans to address these, and are confident that these will lead to a more positive position in the near future.

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 3.6% of total discharges taking place between 10pm and 7am, though some patients self-discharge. In 2019/20, the

Council of Governors will monitor the number of patients who attend the accident and emergency department and only receive advice and guidance, with no further treatment.

The Governors received regular information on system working within Somerset, with Yeovil District Hospital working more closely with Taunton and Somerset NHS Foundation Trust, Somerset Partnership NHS Foundation Trust, the County Council and NHS partners in Dorset. The Governors note that the Trust's priorities for the coming year are in line with those of Taunton and Somerset and of Somerset Partnership, which pay due regard to the use of the Trust's facilities by Dorset residents and that improvements being made are in accordance with 'Fit for My Future'.

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 2018 Staff Survey, which this year had a response rate of 71%, the highest in the country. The results illustrate further improvements in the health and wellbeing of staff, diversity and inclusion, staff morale and staff engagement – to the extent that scores for staff feeling valued (78%), staff recommending YDH as a place to work (70%), and staff recommending YDH as a place to receive care (74%) are all well above the national average.

The Council of Governors continues to actively monitor and receive updates on the recruitment of staff, both for medical and nursing staffing groups. Governors were delighted that, as a result of the overseas recruitment programme, there were no reported nurse vacancies this year and YDH have also been able to help other trusts to address this difficult issue. Work to address medical vacancies is ongoing and Governors will be keen to see more progress with this over the coming year.

The Governors fully support the vision statement, the iCARE philosophy and the principles of good care which continue to underpin all that the hospital does.

Annex 1.1 - Statement from the Somerset Clinical Commissioning Group

NHS Somerset Clinical Commissioning Group is the lead commissioner of health services for the Yeovil District Hospital NHS Foundation Trust (YDH) and we welcome the opportunity to provide this statement and comment on the Trusts Quality Account.

The Quality Account format can be a difficult read and a summary navigating the reader about how the Trust has identified their priorities would be helpful. The data presented gives an accurate position of the YDH local and national quality priorities and quality improvement work undertaken within 2018/19 as well as reporting on the required content as set out by NHS Improvement's Quality Account reporting requirements.

Throughout 2018/19, there have been robust arrangements in place between YDH and the CCG to agree, monitor and review the quality of services through the Clinical Quality Review meeting and the Contract Review Group meetings.

The Trust is to be congratulated for its excellent staff survey results, the latest independent NHS staff survey ranked the Trust the best in the country (out of 230 NHS organisations surveyed) for staff health and wellbeing. The survey offers staff the opportunity to anonymously share their experiences and opinions of their job and their employer to identify

any areas for improvement. The Trust also ranked in the top 20% for areas such as diversity and inclusion, support from managers, staff morale, safety of the hospital environment, bullying and harassment and staff engagement.

The Care Quality Commission (CQC) undertook an inspection visit at Yeovil Hospital between 4 December 2018 and 17 January 2019; the report was published on Wednesday 8 May 2019. While this overall quality rating remains unchanged, inspectors noted clear progress in a number of areas since its previous inspection. Yeovil District Hospital, the trust's main centre, was rated as Good for being effective, caring, responsive and well-led. The hospital was rated requires improvement for being safe. The CQC published the trust's Use of Resources report at the same time, which is based on an assessment undertaken by NHS Improvement. The trust has been rated as Inadequate for using its resources productively. The combined rating for the trust, taking into account CQC's inspection for the quality of services and NHSI's assessment of Use of Resources, is Requires Improvement.

YDH has launched numerous quality improvements during the year; these include focusing on the effectiveness of ward rounds, improving patient discharge pathways and deteriorating patient simulation training. It is notable that the Trust has participated in the full range of national and local clinical audits and that this has resulted in actions to improve quality. Our review will detail comments on the three key areas patient experience, patient safety and clinical effectiveness.

Patient Experience

The Trust continues to embed the principles of iCARE (Communication, Attitude, Respect, and Environment) throughout the organisation and encourages all members of staff to take individual responsibility to help deliver its vision and values. On the NHS website, YDH has a score of 4 out 5 stars with comments from a variety of the services and particular comments about receiving *"Compassion, Care, Communication with a Capital C.....*

YDH received a 47% response rate in the National Adult Inpatient Survey which was higher than the national average of 41%. The Trust has shown an improved performance compared to the previous year with the majority of questions asked showing increased scores. Of note, the following areas had a significantly higher score than the previous year:

- Waiting time to get a bed
- Doctors' explanations that were easy to understand
- Adequate amount of nursing staff for their care
- Feeling emotionally supported
- Patients asked for their views
- Being given information about how to complain about their care

The Trust has maintained a consistent performance with Patient Led Assessments on the Care Environment (PLACE) with improved scores in Food, Dementia and Disability.
YDH have been using magnetic boards behind patient beds as an update for **individual and family involvement;** "ask me about my discharge", "when am I going home?", "What is happening to me?", a summary card for involvement and a variety of mechanisms to empower patients/families to be better involved and engaged with their care, treatment and discharge planning. This is helping to support timely and effective discharge from hospital.

The Trust has acknowledged the importance of hydration and nutrition in recovery from illness or surgery and to maintain good health and have therefore made hydration a priority

area for improvement by implementing quality improvement projects such as flashing cups to remind patients to drink. The Trust participated in International Nutrition and Hydration week and has plans for further improvement in 2019/20.

Yeovil Hospital also took part in the national 70 day #endPJparalysis challenge, which aimed to give patients back one million days of their precious time that would otherwise be spent in a hospital bed. Each day the hospital helped those patients who were able to get up and dressed, swapping hospital gowns and pyjamas for everyday clothes to help them get back on their feet and stay active during their time in hospital. Families and friends were encouraged to support recovery and independence by making sure their loved one had clothes and all their independence aids with them in hospital adding to their sense of wellbeing and identity.

Patient Safety

The Trust continues to work closely with the CCG and other stakeholders in Somerset to improve infection prevention and control through shared learning. A key component in the Trust's reduction of infection is through good hand hygiene by all clinical staff. The Trust consistently scored above the local threshold of 90% throughout 2018/19 with an overall compliance of 95% at the year end.

The Trust should be commended for having no provider-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA-bacteria) bloodstream infections in 2018/19. There were also no Trust attributed cases of Clostridium difficile Infection (CDI).

Screening people for blood stream infection, known as sepsis, has been above 98% in the Emergency Department and 92% on the inpatient wards. Antibiotic administration within one hour has been variable throughout the three quarters with 81.2% overall for ED and 90.9% for inpatients. The CCG acknowledges that sepsis remains a priority for the Trust and compliance will continue to be monitored in 2019/20 through the quality contract meetings.

Clinical Effectiveness

This year Yeovil Hospital has seen its highest number of patients signing up to take part in clinical trials. The Trust is celebrating recruiting 1,000 patients in just 10 months, giving patients the opportunity to help shape the future of how patients and their conditions are treated. The Clinical Research team at Yeovil Hospital is renowned for being very active despite its small size, participating in local, national and international trials. The team is currently running more than 120 studies, including more than 70 new research trials this year.

The Trust commenced implementation of the second version of the National Early Warning Score (NEWS2) in March 2019 and has actively participated in the regional Deteriorating Patient Safety Collaborative which has been focusing on implementing systems to improve recognition and management of deteriorating patients. The Trust successfully won a bid for funding from Health Education England to provide Simulation Training in the wider community and is currently working with partners in Primary Care to improve the pathway for deteriorating patients in the community setting to acute care through the use of NEWS2 and SBAR. After the initial pilot, the Trust aims to spread the project to nursing and care homes.

The Trust continues to work with commissioners and other stakeholders in delivering the National Home First discharge project which, in Somerset, is funded through the Joint Commissioning Board (Somerset Local Authority and the CCG). The Home First service

aim is for patients to be discharged and assessed in either their own home or a bedded facility which is more akin to their usual surroundings. The project aims to support frail, vulnerable people, post-discharge, this is delivered either at home with assessment and support, with community hospital enablement or care home enablement. In its first year, Somerset's Home First initiative has helped 2,000 people leave hospital earlier, avoiding 7,500 nights in hospital and saving £2m. This is a great example of joined up working from health and social care with better outcomes for patients.

Quality Improvement Priorities for 2019/20

The CCG supports the Quality Improvements identified by the Trust for 2019/20 and closer alignment of the priorities across the Somerset Health System with Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust, the key priorities are aligned to national work programs and include:

- Learning from deaths
- Safer Care
- Mental Health and Holistic Care
- Patient Experience
- Right Care, Right Time, Right Place
- Staff Retention and Wellbeing

It is clear that the Trust has demonstrated many areas of effective improvement in patient safety and quality initiatives. The CCG recognises the Trust's continued commitment to working in partnership with commissioners, the public and other key stakeholders and we look forward to again working with the Trust in the forthcoming year.

Please contact me at the address above if you wish to discuss the CCG comments or statement further.

Yours sincerely

Sandra Corry
Director of Quality, Safety and Engagement

Annex 1.2 - Statement from the Dorset Clinical Commissioning Group

In 2018/19 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. We can confirm that we have no reason to believe this Quality Account is not 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, learning from a Never Event that took place in 2017/2018 which has resulted in an increase in the accessibility and availability of Peripherally Inserted Central Catheter (PICC) care training for nurses and the introduction of an amended Surgical Check list *for* procedures such as central venous catheter lines, dialysis lines and PICC lines. In addition, no Never Events have been reported for 2018/2019.

In the report it demonstrates how learning from deaths has continued to have a positive impact, particularly related to supporting timely discussions with patients and their families regarding treatment escalation and resuscitation status for their relative.

The Quality Account highlights that the National Early Warning Score 2 (NEWS 2) has been implemented across the Trust, this has included the on-line training required for all clinical members of staff. Dorset CCG supports the national programme around recognising and treating the deteriorating patient. The collaborative work related to NEWS 2 across the health and social care system in Somerset is recognised as a proactive approach.

The CCG are supportive of the focus of the quality priorities for 2019/2020, the emphasise demonstrated in the priorities are on patient safety, clinical effectiveness, patient experience and staff retention and wellbeing. The six 2019/2020 priorities are the same as the ones from 2018/2019 and include, learning from deaths, safer care, patient experience and staff retention and wellbeing. They were chosen following a review of priorities and progress and a consideration of where further improvements could be made or embedded. The specific focus of these priorities was selected following engagement with patients, families and staff. 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.

Please do not hesitate to contact me if you require any further information.

Yours sincerely

Vanessa Read
Director of Nursing and Quality

Annex 1.3 - Statement from Healthwatch Somerset

Healthwatch Somerset welcomes the opportunity to comment on the draft Yeovil Hospital NHS Foundation Trust Quality Account for 2018-19. Healthwatch Somerset exists to promote the voice of patients and the wider public with respect to health and social care services. 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 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

In reviewing the Trust's priorities and progress against 2018/19 plans, it has considered where future improvement is required and engaged with patient groups, families and staff to identify areas for particular focus. These include learning from mortality reviews, looking at the reason for inpatient falls, and reporting the number of pressure ulcers.

Our comments on the six quality improvement priorities for 2019-20 are:

Priority 1: Learning from incidents, complaints and mortality reviews
We support any action by the Trust to ensure that, when things go wrong, a proper investigation takes place to find out the cause of what went wrong. Also, that learning takes place as a result. And we welcome regular meetings with the Patient Experience and Engagement Steering group to look at how complaints are being used to shape services going forward.

Priority 2: Reduction in avoidable harm
Patient safety has to 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 a number of years.

Priority 3: Increase staff capability to recognise and respond to those with mental health needs
We know that the benefits of integrated care across boundaries (health, social care, employment and housing) are understood. However, integrated care for people with mental health conditions does not always happen. 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.

Priority 4: Improve 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 been a long-standing 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.

Priority 5: Strengthen collaborative working across health and social care
We know that the benefits of collaborative working across health and social care, in particular those regarding discharge, STP involvement and Academy activity are understood. We commend action to strengthen collaborative working to deliver sustainable improvements in care. In particular we note that the Trust has worked collaboratively to improve discharge by way of the development of a discharge checklist, a patient information leaflet to prepare patients for discharge, and the introduction of ward-based dispensing. 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 and reduce staff turnover year on year.

Priority 6: Staff retention and wellbeing
We note that the results of the 2018 Staff Survey show that the Trust continues to improve and is above average in virtually every area. The response rate was 71% compared to the national rate of 44%. 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 are pleased to see that patient engagement and experience is considered throughout the report. 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.

Annex 2 - 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 2018 and March 2019
- Papers relating to quality reported to the Board between April 2018 and March 2019
- 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 2018/19. 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

.....Date 24/5/19 .....Chairman

.....Date 24/5/19 .....Chief Executive

Yeovil District Hospital NHS Foundation Trust

Consolidated Financial Statements For The Year to 31st March 2019

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.

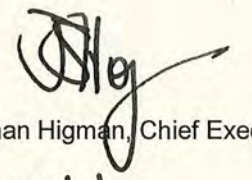
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *Department of Health Group Accounting Manual* the NHS Foundation Trust Annual Reporting Manual and in particular to:

- 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 Yeovil District Hospital NHS Foundation Trust's and the Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve Yeovil District Hospital NHS Foundation Trust or the 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 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: 24/5/19

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: 24 May 2019

KPMG

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 Group") for the year ended 31 March 2019 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2019 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 2018/19 and the Department of Health and Social Care (DHSC) Group Accounting Manual 2018/19.

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 and Trust 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	£3.0 million (2018:£2.7 million) 2.0% of total operating income (2018:1.9%)	
Materiality: Trust financial Statements	£2.6 million (2018:£2.6 million) 1.9% of total operating income (2018:1.9%)	
Risks of material misstatement		**vs 2018**
Recurring risks	Valuation of Land and Buildings	◀▶
	Recognition of NHS and non-NHS Income	◀▶
Event driven	**New** Recognition of Non-Pay Expenditure	▲

2. Material uncertainty related to going concern

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Going concern We draw attention to note 1 to the financial statements which indicates that the Group has net liabilities of £18.5 million as at 31 March 2019. The Group is also forecasting a deficit of £22.2 million for the year ending 31 March 2020 and will require ongoing revenue loan support from the Department of Health and Social Care in terms of non-repayment of current funding in order to meet the future financial obligations of the Group. At present, there are no viable means for the Group to repay its existing DHSC support loans of £83.1 million, or any new ones which are received during 2019/20. 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 and the parent company's ability to continue as a going concern. Our opinion is not modified in respect of this matter.	**Disclosure quality** The financial statements explain how the Board has formed a judgement that it is appropriate to adopt the going concern basis of preparation for the Group and Trust. That judgement is based on an evaluation of the inherent risks to the Group's and Trust financial plan, including the impact of Brexit, and how those risks might affect the Group's and Trust's financial resources or ability to continue operations over a period of at least a year from the date of approval of the financial statements. The risk for our audit is whether or not those risks are such that they amount to a material uncertainty that may cast significant doubt about the ability to continue as a going concern. If so, that fact is required to be disclosed (as has been done) and, along with a description of the circumstances, is a key financial statement disclosure.	Our procedures included: **Funding assessment:** — We inspected and challenged the assumptions in the 2019/20 financial plan to ensure that adequate future loan funding is included. **Our NHS experience:** — We assessed the likelihood of NHS Improvement transferring services to other NHS bodies using our own NHS experience. — We assessed the likelihood of DHSC not demanding repayment of existing loans in the 12 month period under assessment. **Historical comparisons:** — We assessed the Group's performance in meeting its financial targets set in the 2018/19 financial plan, including Control Total, Agency Cap and Cost Improvement Programme. **Assessing transparency:** — We assessed the completeness and accuracy of the matters covered in the going concern disclosure. **Our findings** We found the disclosure of the material uncertainty to be balanced (2018 result: balanced).

3. 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. Going concern is a significant key audit matter and is described in section 2 of our report. We summarise below the, other key audit matters, in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Land and Buildings (£52.9 million; 2018: £48.9 million) *Refer to page 29 (Annual Report - Audit Committee Report), page 21 (accounting policy) and page 41 (financial disclosures)*	**Subjective Valuation: Land and Buildings** Land and buildings are required to be held at current value in existing use. 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 Group 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. Valuations are completed by an external expert, engaged by the Group 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. The Trust had a desktop revaluation undertaken by an external valuer at 31 March 2019, resulting in a £2.8 million increase in the value of land and buildings. Valuations are inherently judgemental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, were appropriate and correctly applied. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	Our procedures included: — **Assessing valuer's credentials:** We considered the scope, qualifications and experience of the Group's valuer, to identify whether the valuer was appropriately experienced and qualified to undertake the valuation; — **Test of detail:** We undertook the following tests of detail: — We tested the completeness of the estate covered by the valuation to the Group's underlying estate records, including additions to land and buildings during the year; — We critically assessed the assumptions used within the valuation by assessing the assumptions used to derive the carrying value of assets against the BCIS all-in tender price index and industry norms; — We tested the accuracy of the estate base data provided to the valuer to complete the desktop valuation to ensure it accurately reflected the Group's estate; — We re-performed the calculation of gains or losses on revaluation for all applicable assets and checked whether the accounting entries were consistent with the DHSC Group Accounting Manual; 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.

3. Key audit matters: our assessment of risks of material misstatement

	The risk	Our response
NHS and non-NHS income (£153.8 million; 2018: £144.9 million) *Refer to page 29 (Annual Report - Audit Committee Report), page 20 (accounting policy) and page 33 (financial disclosures)*	**Effects of Irregularities:** Of the Group's reported income from activities, £132.0 million (2017/18, £120.4 million) came from commissioners (Clinical Commissioning Groups (CCG) and NHS England). This represents 86% 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 Group does not meet its contracted KPIs then Commissioners are able to impose fines, reducing the level of income from contracts. 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 other income of £21.8 million (2017/18: £24.5 million) from other activities principally, Private Patient income, Provider Sustainability Funding and Education and Training. Much of this income is generated by contracts with other NHS and non-NHS bodies which are based on achieving financial targets, varied payment terms, including payment on delivery, milestone payments and periodic payments. As such there is a fraudulent risk of revenue recognition over both NHS and Non-NHS income.	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 2019 to determine whether income was recognised in the correct accounting period, in accordance with the amounts billed to corresponding parties; — We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant income recorded in the Group's financial statements to the expenditure balances recorded within the accounts of Commissioners. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Groups's approach to recognising income from Commissioners; — We assessed the judgements made to received the transformation funding recorded in the financial statements as part of 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 recognition of NHS and non-NHS income to be balanced.

3. Key audit matters: our assessment of risks of material misstatement

	The risk	Our response
Non-Pay Expenditure recognition Other expenditure (59.3 million; 2017/2018: £57.5 million) *Refer to page 29 (Annual Report - Audit Committee Report), page 21 (accounting policy) and page 35 (financial disclosures)*	**Effects of Irregularities:** As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Group may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of recognition of non-pay expenditure at the year-end.	Our procedures included: — **Control observation:** We tested the design and operation of process level controls over expenditure approval; — **Test of Details:** We undertook the following tests of details: — We agreed a specific item sample of non pay expenditure transactions to supporting evidence and cash; — We inspected invoices for material expenditure in the month prior to and following 31 March 2019 to determine whether expenditure was recognised in the correct accounting period relevant to when services were delivered; — We assessed the completeness and judgements made within the expenditure balance, specifically accrued expenditure; — We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant payables recorded in the Group's financial statements to the receivables balances recorded within the accounts of other providers and other bodies within the AoB boundary. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Group's approach to recognising expenditure with other providers and other bodies within the AoB boundary. **Our findings** We found the resulting recognition of non-pay expenditure to be balanced.

We continue to perform procedures over Property Plant and Equipment, Investments, Intercompany Receivables, Intercompany Payables and Loans (Trust only disclosures). However, following the one-off transfer of Trust estate in 2017/18, we have not assessed this as one of the most significant risks in our current year audit and, therefore, it is not separately identified in our report this year.

4. 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 £3.0 million (2018: £2.8 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

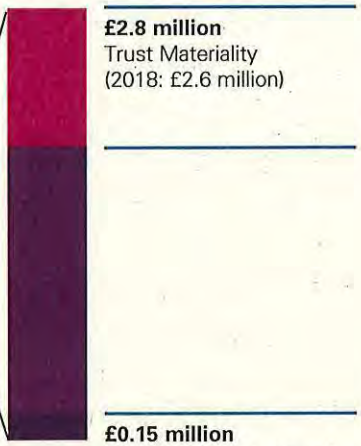
Materiality for the parent Trust's financial statements as a whole was set at £2.8 million (2018: £2.6 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.9%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.15 million (2018: £0.13 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Of the group's 5 (2018: 5) reporting components, we subjected 5 (2018: 5) to full scope audits for group purposes.

Total Group Income
£153.7 million (2018: £144.6 million)

Group Materiality
£3.0 million (2018: £2.8 million)



5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

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 2018/19, 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.

6. 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 their 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.

Our conclusion on the Group's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified/adverse

Under the Code of Audit Practice we are required to report to you if the Group has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Qualified conclusion

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 Group put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

As at 31 March 2019, the Group reported a £19.0 million deficit against a forecast outturn position of £19.9 million. The Group required £20.8 million of revenue support borrowings in year to support the cash position and is expecting to not repay borrowings due in 2019/20. The Group operational plan for 2019/20 forecasts a deficit of £22.2 million (before Transformational Funding), and the Group does not currently have plans in place to address the underlying deficit. Whilst the Group has identified efficiency schemes that will support the achievement of the Group's short-term financial plans, its long-term plans are not yet sufficiently progressed to achieve a break-even position in the foreseeable future or an ability to repay the loans from the DHSC.

This demonstrates weaknesses in the Group's arrangements to plan its finances effectively to support the sustainable delivery of its strategic priorities and maintain its statutory functions

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Group 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 Group 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 Group'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 Group had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Group'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 Group'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 Group, 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 risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial Sustainability	Whilst the context of the financial challenges within the NHS is noted, the deficit presents a significant risk to our assessment of the adequacy of arrangements in place at the Group specifically in relation to planning finances effectively. The Group continues to operate with an underlying deficit, with no medium term plans to returned to a break even position. It is reliant on DHSC loans to support the cash position.	**Our work included:** — Considering the nature of cash support the Group is receiving from NHSI and its performance against any conditions attached to the support. — Assessing the Group'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 Group CIP delivery against the planned CIP target and the use of recurrent and non-recurrent savings. — Comparing the Group use of agency staff against the agency cap set by NHS Improvement. — Evaluating the Group position as at 31 March 2019 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 2019 the Parent Trust has reported a £21.4 million deficit against planned deficit of £19.9 million. The Group reported a £19.0 million deficit. — The CQC have issued a 'requires improvement' overall rating, however the Use of Resources rating was inadequate. — The Group cash balance at year end was £5.0 million, with the Group requiring £20.8 million of revenue support borrowings in year, taking the total loan balance to £83.1 million. — The 2019/20 operational plan forecasts a breakeven position that is reliant on £19.3 million non-recurrent central funding. The plan was submitted following collaboration with Somerset STP. The Group plan no further loan drawdowns from DHSC in 2019/20, though their plan is reliant on current loans not being repaid. — The Group delivered £6.0 million of the £6.3 million Cost Improvement Plans for 2018/19, of which 63% are recurrent savings. — The Group has incurred £6.2 million of agency expenditure against an agreed agency cap of £5.6 million. These findings demonstrated weaknesses in the Groups arrangements to plan its finances effectively to support the sustainable delivery of its strategic priorities and maintain its statutory functions.

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 Group. 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 Group, 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

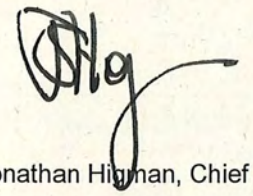
Rees Batley
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
66 Queen Square,
Bristol, BS1 4BE
28 May 2019

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2019 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 24 May 2019

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

		Group		Trust	
		2018/19	2017/18	**2018/19**	2017/18
	Note	**£'000**	£'000	**£'000**	£'000
Operating income from patient care activities	3	**131,983**	120,405	**119,510**	113,152
Other operating income	4	**21,788**	24,487	**25,036**	28,052
Total operating income		**153,771**	144,892	**144,546**	141,204
Operating expenses	5	**(171,852)**	(163,894)	**(164,177)**	(158,241)
Operating Deficit		**(18,081)**	(19,002)	**(19,631)**	(17,037)
Finance income	9	**40**	27	**1,113**	200
Finance expenses	9	**(1,553)**	(725)	**(2,822)**	(895)
Net finance costs		**(1,513)**	(698)	**(1,709)**	(695)
Gain/(loss) on disposal of non-current assets	10	**744**	(68)	**(80)**	306
Share of (losses) of associates/joint arrangements		**(72)**	(4)	**0**	(4)
Corporation tax expense		**(109)**	(46)	**0**	0
Deficit for the year		**(19,031)**	(19,818)	**(21,420)**	(17,430)
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	11	**(1,765)**	(552)	**0**	(552)
Revaluations	15	**4,721**	522	**4,358**	515
Other reserve movements		**(15)**	173	**0**	173
Total comprehensive expense for the period		**(16,090)**	(19,675)	**(17,062)**	(17,294)
Deficit for the period attributable to:					
non-controlling interests; and		**144**	(102)	**0**	0
the Foundation Trust		**(19,175)**	(19,716)	**(21,420)**	(17,430)
Total Deficit		**(19,031)**	(19,818)	**(21,420)**	(17,430)
Total comprehensive income expense for the period attributable to:					
non-controlling interests; and		**144**	(102)	**0**	0
the Foundation Trust		**(16,234)**	(19,573)	**(17,062)**	(17,294)
Total comprehensive income expense		**(16,090)**	(19,675)	**(17,062)**	(17,294)

All results relate to continuing operations

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

		Group		Trust	
		31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	Note	**£'000**	£'000	**£'000**	£'000
Non current assets					
Intangible assets	14	**5,115**	4,805	**4,805**	4,805
Property, plant and equipment	15	**60,466**	57,900	**58,536**	54,999
Investments in associates and joint ventures	22.1	**139**	211	**15,124**	15,149
Trade and other receivables	17	**762**	604	**32,501**	32,664
Total non current assets		**66,482**	63,520	**110,966**	107,617
Current assets					
Inventories	16	**2,303**	2,077	**1,440**	1,232
Trade and other receivables	17	**12,549**	13,019	**11,025**	15,839
Cash and cash equivalents	18	**5,021**	4,632	**243**	675
Total current assets		**19,873**	19,728	**12,708**	17,746
Current liabilities					
Trade and other payables	20	**(20,576)**	(23,124)	**(16,830)**	(15,107)
Borrowings	22	**(35,668)**	(18,317)	**(38,045)**	(25,247)
Provisions	21	**(75)**	(80)	**(32)**	(80)
Other Liabilities		**-**	(245)	**(1,156)**	(2,109)
Total current liabilities		**(56,319)**	(41,766)	**(56,063)**	(42,543)
Total assets less current liabilities		**30,036**	41,482	**67,611**	82,820
Non current liabilities					
Trade and other payables	20	**(132)**	(131)	**0**	0
Borrowings	22	**(47,480)**	(43,106)	**(87,325)**	(85,786)
Provisions	21	**(867)**	(850)	**(894)**	(833)
Total non current liabilities		**(48,479)**	(44,087)	**(88,219)**	(86,619)
Total assets employed		**(18,443)**	**(2,605)**	**(20,608)**	**(3,799)**
Financed by					
Public dividend capital	25	**42,342**	42,089	**42,342**	42,089
Revaluation reserve		**12,535**	9,580	**4,722**	364
Income and expenditure reserve		**(74,958)**	(56,525)	**(67,672)**	(46,252)
Non-controlling interest		**(60)**	(204)	0	0
Charitable fund reserves		**1,698**	2,454	0	0
Total taxpayers' & others' equity		**(18,443)**	(2,605)	**(20,608)**	(3,799)

The notes on pages 15 – 57 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 24 May 2019

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 2018/2019

	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 2018	(2,606)	2,454	42,089	9,580	(56,525)	(204)
Surplus/(Deficit) for the year	(19,031)	(756)	0	0	(18,419)	144
Revaluation gains/(losses) and impairment losses property, plant and equipment	2,956	0	0	2,956	0	0
Public Dividend Capital received	253	0	253	0	0	0
Movements on other reserves	(15)	0	0	(1)	(14)	0
Total Comprehensive income for the year	(15,837)	(756)	253	2,955	(18,433)	144
Taxpayers' Equity at 31 March 2019	**(18,443)**	**1,698**	**42,342**	**12,535**	**(74,958)**	**(60)**

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)**

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 2019

	Note	Group 2018/19 £'000	Group 2017/18 £'000	Trust 2018/19 £'000	Trust 2017/18 £'000
Cash flows from operating activities					
Operating deficit		**(18,081)**	(19,002)	**(19,631)**	(17,853)
Non-cash income and expense:					
Depreciation and amortisation		**4,001**	4,132	**4,140**	4,065
Net impairments and reversals of impairments		**101**	221	**(1,498)**	221
Income recognised in respect of capital donations		**(728)**	(1,220)	**(728)**	(1,220)
(Increase)/decrease in receivables		**314**	(4,430)	**6,321**	(39,794)
(Increase)/decrease in inventories		**(226)**	(50)	**(208)**	785
Increase/(decrease) in payables and other liabilities		**(3,049)**	8,334	**1,723**	703
Increase/(decrease) in provisions		**12**	(315)	**12**	0
Corporation tax (paid)		**0**	(47)	**0**	0
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		**(665)**	185	**0**	0
Net cash used in operations		**(18,321)**	(12,192)	**(9,869)**	(53,093)
Cash flows from investing activities					
Interest received	9	**20**	16	**1,113**	15
Payments to acquire intangible assets	14	**(842)**	(1,138)	**(849)**	(1,138)
Payments to acquire tangible fixed assets	15	**(2,952)**	(3,811)	**(2,463)**	(1,830)
Sale of property,plant and equipment	15	**2,471**	0	**0**	0
Receipt of cash donations to purchase capital assets		**20**	0	**0**	0
Net cash used in investing activities		**(1,283)**	(4,933)	**(2,199)**	(2,953)
Cash flows from financing activities					
Public Dividend Capital received	25	**253**	225	**253**	225
Loans received from Department of Health	22	**20,857**	17,216	**20,857**	17,216
Movements on other loans		**616**	(393)	**(6,701)**	38,782
Interest paid on loans		**(1,332)**	(437)	**(2,822)**	(437)
Loans repaid - including finance lease capital		**(155)**	(143)	**(155)**	(143)
Interest element of finance lease		**(53)**	(88)	**(53)**	(88)
Other capital movements		**(193)**	(89)	**257**	(63)
PDC dividends received		**0**	29	**0**	29
Charitable fund financing activities		**0**	11	**0**	0
Net cash used in financing activities		**19,993**	16,331	**11,636**	55,521
Increase / (Decrease) in cash and cash equivalents		**389**	(794)	**(432)**	(525)
Cash and cash equivalents at 1 April		**4,632**	5,426	**675**	1,200
Cash and cash equivalents at 31 March	18	**5,021**	4,632	**243**	675

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 Group 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 NHS Improvement foundation trust annual reporting manual 2018/19 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 Group and financial plans have been developed and published for future years. As the Group has operated with a deficit from 2015/16 and plans to break-even in 2019/20 the Board did consider the principle of going concern and ongoing financing.

The Group has received revenue and capital loans from the Department of Health (DOH) enabling the Trust to meet its obligations. The 2019/20 financial plans and cash flow forecasts have been prepared on the assumption that no further loan support will be received from DOH, and existing loans will be renewed as and when they fall due.

As with any Group placing reliance on the Department of Health and Social Care for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of the approval of these financial statements, they have no reason to believe that it will not do so.

Although these factors represent material uncertainties that cast doubt about the Group'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.

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 2019 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 2019 was £12.4m.

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 2019 was £26.5m and forms part of the consolidated accounts.

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 2019 was £6.9m.

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 desktop valuation was carried out as at 31 March 2019. 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
Building	9 to 100
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 al

so 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 2018/19. 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 2018/19 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 £53.5 million (2017/18 £47.8 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.

The majority of the Trusts estate is considered to be specialised assets as there is no open market for an acute hospital. The modern equivalent asset valuation is based on the assumption that a replacement hospital would be built on an alternative site, within the surrounding area of Yeovil.

Revisions to accounting estimates are recognised in the period in which the estimate is revised.

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 2018/19 financial year end, the estimated value of partially completed spells is £631,877 (2017/18 £640,215).

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 14 Regulatory Deferral Accounts

IFRS 16 Leases

IFRIC 23 Income Tax Treatment

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 2018/2019. 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 Group has adopted the following new accounting standards,

IFRS 9 Financial Instruments

IFRS 9 as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £204k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £2k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £420k.

IFRS 15 - Revenue from Contracts with Customers

IFRS 15 as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services. Consequently, following adoption of IFRS 15 for the year ended 31 March 2019 there was no movement in revenue.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

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.

	Elective Care £000	**Urgent Care £000**	**Total £000**
NHS Clinical Income	51,343	64,300	115,643
Private Care Income	2,464		2,464
Total Income	**53,807**	**64,300**	**118,107**
Total Expenditure	**(61,963)**	**(73,524)**	**(135,487)**
Segmental Surplus / (Deficit)	**(8,156)**	**(9,224)**	**(17,380)**
SHS			**(894)**
Charitable funds			**(757)**
Consolidated Income Statement			**(19,031)**

YDH PLICS reporting is set up to mirror the two clinical strategic business units of the Trust Elective Care and Urgent Care. Individual specialty service level positions group up in to one of these two business units. Cost and income are inclusive of all subsidiaries that support the running of the core Acute services, including YDH Trust, Daycase UK and Simply Serve Ltd. Symphony Healthcare Services is separate to our core Acute work and is not included in our PLICS reporting.

3. Operating income from patient care activities

3.1 Income from patient care activities (by nature)

	Group		Trust	
	2018/19	2017/18	**2018/19**	2017/18
	£'000	£'000	**£'000**	£'000
Clinical Income				
A & E income	**6,917**	6,341	**6,917**	6,341
Community services income	**0**	333	**0**	333
Elective income	**17,825**	17,072	**17,752**	17,072
High cost drugs income	**10,992**	10,023	**10,992**	10,023
Non-elective income	**35,799**	35,635	**35,799**	35,635
Other non protected clinical income	**439**	386	**439**	386
Other NHS clinical income	**38,128**	31,103	**25,919**	23,987
Outpatient income - Firsts	**7,261**	7,055	**7,261**	7,055
Outpatient income - Follow ups	**10,885**	10,522	**10,885**	10,522
Private patient income	**2,464**	1,935	**2,273**	1,798
AFC Pay award central funding	**1,273**	0	**1,273**	0
Clinical income from activities	**131,983**	120,405	**119,510**	113,152

3.2 Income from patient care activities (by source)

	Group		Trust	
	2018/19	2017/18	**2018/19**	2017/18
	£'000	£'000	**£'000**	£'000
CCG's and NHS England	**127,174**	117,441	**114,457**	110,300
Other NHS Foundation Trusts	**579**	535	**513**	547
Departement of Health and Social Care	**1,273**	0	**1,273**	13
Non - NHS: private patients	**2,463**	1,935	**2,273**	1,798
Non - NHS: overseas patients	**55**	108	**555**	108
NHS injury recovery scheme (was RTA)	**439**	386	**439**	386
Total income from activities	**131,983**	120,405	**119,510**	113,152

NHS Injury Scheme income is subject to a provision for doubtful debts of 21.89% for 18/19 which has decreased from 22.84% in 17/18 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.

Group and Trust

	2018/19	2017/18
	£'000	£'000
Income from services designated (or grandfathered) as commissioner requested services	**129,081**	118,084
Income from services not commissioner requested	**2,902**	2,321
Total	**131,983**	120,405

3.4 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	Trust	
	2018/19	2017/18
	£'000	£'000
Income recognised this year	**55**	108
Cash payments received in-year	**24**	49
Amounts added to provision for impairment of receivables	**35**	12
Amounts written off in-year	**3**	-

4 Other operating income

	Group		**Trust**	
	2018/19	2017/18	**2018/19**	2017/18
	£'000	£'000	**£'000**	£'000
Research and development	**896**	682	**896**	682
Education and training	**4,268**	4,019	**4,268**	4,019
Receipt of capital grants and donations	**728**	1,220	**728**	1,220
PSF Income	**3,374**	1,834	**3,374**	1,834
Incoming resources received by NHS charitable funds	**464**	444	**0**	0
Vanguard project income	**0**	3,435	**0**	3,435
Other income	**12,058**	12,853	**15,770**	16,862
Total other operating income	**21,788**	24,487	**25,036**	28,052

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

4.1 Additional information on contract revenue (IFRSR 15) recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	0
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0

5 Operating expenses

5.1 Operating expenses comprise

		Group		Trust	
		2018/19	2017/18	**2018/19**	2017/18
	Note	**£'000**	£'000	**£'000**	£'000
Clinical negligence insurance		**4,220**	3,804	**4,220**	3,804
Consultancy costs		**374**	923	**324**	913
Depreciation and amortisation		**4,001**	4,132	**4,140**	4,065
Drug costs		**16,226**	15,349	**15,934**	15,152
Establishment		**3,578**	4,482	**836**	3,915
Fees for Audit					
- Statutory audit		**59**	59	**59**	59
- Associate Companies		**27**	15	**27**	9
- Audit Related Assurance Services		**10**	7	**10**	7
Internal audit fees		**60**	54	**60**	54
Tax advisory services		**219**	26	**67**	26
Impairments	11	**101**	221	**1,497**	221
Increase in provisions		**12**	229	**97**	145
Legal fees		**232**	410	**60**	219
Losses, ex gratia & special payments		**17**	43	**17**	43
NHS charities expenditure		**1,240**	1,529	**0**	0
Premises		**8,887**	8,284	**3,842**	6,962
Purchase of healthcare from non NHS bodies *		**5,553**	3,769	**26,025**	6,844
Rentals under operating leases	5.3	**623**	582	**8**	481
Services from:					
- CCGs and NHS England		**20**	575	**284**	0
- NHS Foundation Trusts		**2,385**	2,741	**3,836**	4,587
- NHS Trusts		**277**	453	**279**	0
Staff costs:					
- Executive Directors'	6	**1,207**	1,310	**915**	1,255
- Other Staff costs	6	**106,737**	100,345	**87,106**	90,785
- Redundancy costs	6	**510**	553	**510**	553
- Non-Executive Directors' costs		**116**	117	**116**	117
Supplies and services (excluding drug costs)					
- Clinical		**9,641**	8,435	**4,073**	7,532
- General		**2,947**	3,073	**8,153**	9,001
Training		**484**	437	**417**	427
Transport		**1,118**	921	**1,032**	906
Other		**971**	1,016	**233**	159
		171,852	163,894	**164,177**	158,241

* The Trust figure includes intercompany expenditure with non NHS wholly owned subsidiaries.

5.2 Limitation on auditor's liability

The limitation on the auditor's liability is £2.0m. (2017/18: £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	
	2018/19 £'000	2017/18 £'000	**2018/19 £'000**	2017/18 £'000
Operating lease expense				
Minimum lease payments	**623**	582	**8**	481
	623	582	**8**	**481**
Future minimum lease payments due:				
- not later than one year;	**671**	630	**481**	481
- later than one year and not later than five years;	**1,677**	1,446	**960**	968
- later than five years.	**668**	36	**36**	36
Total	**3,016**	2,112	**1,477**	1,485

6 Staff costs

6.1 Staff costs

	Group		Trust	
	2018/19 £'000	2017/18 £'000	**2018/19 £'000**	2017/18 £'000
Salaries and wages (excluding NEDS)	**84,143**	78,522	**68,116**	71,737
Social security costs	**7,771**	7,517	**7,088**	6,868
Employer contributions to NHSPA	**9,029**	8,707	**8,083**	8,534
Termination benefits	**510**	553	**510**	553
Apprenticeship levy	**625**	348	**625**	348
Agency and contract staff	**6,376**	6,561	**4,109**	4,553
	108,454	102,208	**88,531**	92,593

6.2 Employee benefits

Benefits in kind relating to lease cars totalled £109,265 in the year (2017/18 £107,561). 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 2019 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 2018/19 there was one early retirement from the trust agreed on the grounds of ill-health (2017/18: Nil). The estimated additional pension liability of this ill-health retirement is £15,000 (2017/18: £Nil).

9 Finance income and expenses

Group and Trust

	2018/19 £'000	2017/18 £'000
Finance Income		
Trust interest received	**20**	15
Charity interest received	**20**	12
	40	27
Finance Expense		
Interest on loan from Department of Health	**(1,423)**	(553)
Commercial Loans	**(77)**	(83)
Interest on finance leases	**(53)**	(88)
Unwiding of discount on provisions	**0**	(1)
	(1,553)	(725)

10 Gains / losses on disposal/de-recognition of non-current assets

	Group		**Trust**	
	2018/19 £'000	2017/18 £'000	**2018/19 £'000**	2017/18 £'000
Gain/(Loss) on disposal of fixed asset	**(80)**	(68)	**(80)**	306
Gain on disposal of property	**824**	0	**0**	0
	744	(68)	**(80)**	306

The disposals in 2018/19 were in respect of non-protected assets.

11 Impairment of assets

	Group		**Trust**	
	2018/19 £'000	2017/18 £'000	**2018/19 £'000**	2017/18 £'000
Changes in market price	**101**	221	**1,497**	221
Total net impairments charged to operating deficit	**101**	221	**1,497**	221
Impairments charged to the revaluation reserve	**1,765**	552	**0**	552
Total net impairments	**1,866**	773	**1,497**	773

A desktop valuation of the land, buildings and dwellings was carried out as at 31 March 2019.

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	**2018/19**		2017/18	
	Number	**Value £'000**	Number	Value £'000
Losses of Cash:				
Due to overpayment of salary	**0**	**0**	0	0
Bad Debts				
Private Patients	**2**	**0**	0	0
Overseas Visitors	**7**	**3**	1	0
Other	**16**	**0**	10	8
Damage to building:				
Not theft or fraud	**0**	**0**	0	0
Ex Gratia payments:				
Loss of personal effects	**17**	**12**	23	9
Other	**4**	**17**	6	26
Recovered Losses:				
Compensation Payments Received	**1**	**(15)**	1	(65)
Total losses and special payments	**47**	**17**	41	(22)

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	2018/19 Software licence	2018/19 Development	2018/19 Assets under construction	2018/19 Total	2017/18 Software licence	2017/18 Development	2017/18 Assets under construction	2017/18 Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April	**1,560**	**2,877**	**2,083**	**6,520**	1,649	2,828	1,122	5,599
Additions - purchased	**105**	**0**	**744**	**849**	100	3	965	1,068
Additions - leased	**0**	**0**	**0**	**0**	553	0	100	653
Reclassifications	**19**	**0**	**(19)**	**0**	4	0	(4)	0
Disposals	**(10)**	**0**	**0**	**(10)**	(700)	-	(100)	-800
At 31 March	**1,674**	**2,877**	**2,808**	**7,359**	1,606	2,831	2,083	6,520
Amortisation at 1 April	**1,141**	**574**	**0**	**1,715**	1,066	246	0	1,312
Provided during the year	**203**	**328**	**0**	**531**	267	328	0	595
Disposals	**(2)**	**0**	**0**	**(2)**	(192)	0	0	(192)
Amortisation at 31 March	**1,342**	**902**	**0**	**2,244**	1,141	574	0	1,715
Net book value								
- Purchased at 1 April	**419**	**2,303**	**2,083**	**4,805**	583	2,628	1,122	4,333
	419	**2,303**	**2,083**	**4,805**	583	2,628	1,122	4,333
Net book value								
- Purchased at 31 March	**332**	**1,975**	**2,808**	**5,115**	419	2,303	2,083	4,805
Total at 31 March	**332**	**1,975**	**2,808**	**5,115**	419	2,303	2,083	4,805

15 Property plant and equipment

15.1 Property, plant and equipment at 31 March 2019 comprise the following elements

Group	Freehold Land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction & payments on account	Plant and machinery	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2018	4,642	52,979	1,351	2,126	16,533	2,412	1,152	**81,195**
Additions - purchased	32	2,095	0	515	850	529	48	**4,069**
Additions - leased	0	103	0	0	0	0	0	**103**
Additions - donated	0	507	0	102	108	9	2	**728**
Reclassifications	0	1,922	0	(1,989)	67	0	0	**0**
Impairments charged to revaluation reserve	0	(1,866)	0	0	0	0	0	**(1,866)**
Revaluation	(31)	2,955	18	0	0	0	0	**2,942**
Disposals	0	(1,776)	0	0	(94)	(6)	(2)	**(1,878)**
At 31 March 2019	**4,643**	**56,919**	**1,369**	**754**	**17,464**	**2,944**	**1,200**	**85,293**
Depreciation at 1 April 2018	51	8,640	720	0	11,855	1,552	477	**23,295**
Provided during the year	0	1,862	48	0	1,300	175	85	**3,470**
Impairments	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	**0**
Reclassifications	0	(2)	0	0	2	0	0	**0**
Revaluation	0	(1,731)	(48)	0	0	0	0	**(1,779)**
Disposals	0	(129)	0	0	(27)	(2)	(1)	**(159)**
Accumulated depreciation at 31 March 2019	**51**	**8,640**	**720**	**0**	**13,130**	**1,725**	**561**	**24,827**
Net book value								
- Purchased at 1 April 2018	4,591	40,807	631	1,043	3,801	860	505	**52,238**
- Finance Leases at 1 April 2018	0	1,284	0	1,083	214	0	0	**2,581**
- Donated at 1 April 2018	0	2,249	0	0	662	0	170	**3,081**
Total at 1 April 2018	**4,591**	**44,340**	**631**	**2,126**	**4,677**	**860**	**675**	**57,900**
- Purchased at 31 March 2019	4,592	45,471	649	593	3,659	1,210	489	**56,663**
- Finance Leases at 31 March 2019	0	1,353	0	0	0	0	0	**1,353**
- Donated at 31 March 2019	0	1,456	0	161	674	9	150	**2,450**
Total at 31 March 2019	**4,592**	**48,279**	**649**	**754**	**4,334**	**1,219**	**639**	**60,466**

Trust

	Freehold Land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction & payments on account	Plant and machinery	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2018	4,591	41,120	631	2,126	5,138	880	501	**54,987**
Additions - purchased	32	2,095	0	515	839	86	48	**3,615**
Additions - leased	0	103	0	0	0	0	0	**103**
Additions - donated	0	508	0	102	108	9	2	**729**
Reclassifications	0	1,923	0	(1,989)	67	0	0	**1**
Impairments charged to operating expenses	(32)	(1,540)	0	0	0	0	0	**(1,572)**
Revaluation	1	2,359	18	0	0	0	0	**2,378**
Disposals	0	0	0	0	(94)	(6)	(2)	**(102)**
At 31 March 2019	**4,592**	**46,568**	**649**	**754**	**6,058**	**969**	**549**	**60,139**
Depreciation at 1 April 2018	0	0	0	0	42	31	0	**73**
Provided during the year	0	2,002	48	0	1,298	175	85	**3,608**
Impairments	0	(73)	0	0	0	0	0	**(73)**
Reversal of impairments	0	(1)	0	0	0	0	0	**(1)**
Reclassifications	0	(2)	0	0	2	0	0	**0**
Revaluation	0	(1,926)	(48)	0	0	0	0	**(1,974)**
Disposals	0	0	0	0	(27)	(2)	(1)	**(30)**
Accumulated depreciation at 31 March 2019	**0**	**0**	**0**	**0**	**1,315**	**204**	**84**	**1,603**
Net book value								
- Purchased at 1 April 2018	4,591	37,587	631	1,043	4,212	848	329	**49,241**
- Finance Leases at 1 April 2018	0	1,284	0	0	214	0	0	**1,498**
- Donated at 1 April 2018	0	2,249	0	1,083	670	0	171	**4,173**
Total at 1 April 2018	**4,591**	**41,120**	**631**	**2,126**	**5,096**	**848**	**500**	**54,912**
- Purchased at 31 March 2019	1,229	11,889	649	593	1,340	512	65	**16,277**
- Finance Leases at 31 March 2019	3,363	33,324	0	0	2,728	244	250	**39,909**
- Donated at 31 March 2019	0	1,356	0	161	674	9	150	**2,350**
Total at 31 March 2019	**4,592**	**46,568**	**649**	**754**	**4,743**	**765**	**465**	**58,536**

15.2 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	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2017	4,357	54,196	1,404	507	16,284	2,044	949	**79,741**
Additions - purchased	0	1,010	0	2,057	641	519	237	**4,464**
Reclassifications	0	301	0	(391)	90	0	0	**0**
Impairments charged to revaluation reserve	0	(2,588)	(16)	0	0	0	0	**(2,604)**
Revaluation	285	60	(37)	0	(17)	0	(1)	**290**
Disposals	0	0	0	(47)	(465)	(151)	(33)	**(696)**
At 31 March 2018	**4,642**	**52,979**	**1,351**	**2,126**	**16,533**	**2,412**	**1,152**	**81,195**
Depreciation at 1 April 2017	51	8,605	720	0	11,143	1,540	392	**22,451**
Provided during the year	0	2,039	59	0	1,162	160	117	**3,537**
Impairments	0	347	0	0	0	0	0	**347**
Reversal of impairments	0	(2,162)	(16)	0	0	0	0	**(2,178)**
Revaluation	0	(189)	(43)	0	0	0	0	**(232)**
Disposals	0	0	0	0	(450)	(148)	(32)	**(630)**
Accumulated depreciation at 31 March 2018	**51**	**8,640**	**720**	**0**	**11,855**	**1,552**	**477**	**23,295**
Net book value								
- Purchased at 1 April 2017	4,306	41,996	684	486	4,186	504	386	**52,548**
- Finance Leases at 1 April 2017	0	1,329	0	0	279	0	0	**1,608**
- Donated at 1 April 2017	0	2,266	0	21	676	0	171	**3,134**
Total at 1 April 2017	**4,306**	**45,591**	**684**	**507**	**5,141**	**504**	**557**	**57,290**
- Purchased at 31 March 2018	4,591	40,807	631	1,043	3,801	860	505	**52,238**
- Finance Leases at 31 March 2018	0	1,284	0	1,083	214	0	0	**2,581**
- Donated at 31 March 2018	0	2,249	0	0	662	0	170	**3,081**
Total at 31 March 2018	**4,591**	**44,340**	**631**	**2,126**	**4,677**	**860**	**675**	**57,900**

Trust	Freehold Land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction & payments on account	Plant and machinery	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2017	4,306	43,867	684	507	16,255	2,005	935	**68,564**
Additions - purchased	0	1,010	0	2,144	647	519	41	**4,361**
Additions - leased	3,363	34,895	0	808	5,261	459	525	**45,311**
Reclassifications	0	301	0	(391)	90	0	0	**0**
Impairments charged to revaluation reserve	0	(2,588)	(16)	0	0	0	0	**(2,604)**
Revaluation	285	60	(37)	0	(24)	0	(1)	**283**
Sale of Assets (Disposal)	(3,363)	(36,425)	0	(808)	(4,834)	(439)	(522)	**(46,391)**
Disposals	0	0	0	(47)	(465)	(151)	(33)	**(696)**
At 31 March 2018	**4,591**	**41,120**	**631**	**2,213**	**16,930**	**2,393**	**945**	**68,828**
Depreciation at 1 April 2017	0	0	0	0	11,122	1,533	392	**13,052**
Provided during the year	0	2,004	59	0	1,162	160	85	**3,470**
Impairments	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	(1,690)	(16)	0	0	0	0	**(1,706)**
Revaluation	0	(314)	(43)	0	0	0	0	**(357)**
Disposals	0	0	0	0	(450)	(148)	(32)	**(630)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**0**	**11,834**	**1,545**	**445**	**13,829**
Net book value								
- Purchased at 1 April 2017	4,306	40,271	684	486	4,180	472	372	**50,771**
- Finance Leases at 1 April 2017	0	1,326	0	0	279	0	0	**1,605**
- Donated at 1 April 2017	0	2,270	0	21	674	0	171	**3,136**
Total at 1 April 2017	**4,306**	**43,867**	**684**	**507**	**5,133**	**472**	**543**	**55,512**
- Purchased at 31 March 2018	4,591	37,587	631	1,043	4,212	848	329	**49,241**
- Finance Leases at 31 March 2018	0	1,284	0	0	214	0	0	**1,498**
- Donated at 31 March 2018	0	2,249	0	1,083	670	0	171	**4,173**
Total at 31 March 2018	**4,591**	**41,120**	**631**	**2,126**	**5,096**	**848**	**500**	**54,912**

16 Inventories

	Group		Trust	
	31 March 2019 £'000	31 March 2018 £'000	**31 March 2019 £'000**	31 March 2018 £'000
Drugs	**1,149**	1,072	**1,091**	1,138
Consumables	**1,137**	1,003	**332**	92
Energy	**17**	2	**17**	2
	2,303	2,077	**1,440**	1,232

Inventories recognised in expenses for the year were £nil (2017/18: £50,000).

17 Trade and other receivables

17.1 Trade and other receivables

	Group		Trust	
	31 March 2019 £000	**31 March 2018 £000**	**31 March 2019 £000**	**31 March 2018 £000**
Current				
Contract receivables*	10,891	0	5,499	0
Trade receivables*	0	4,789	0	4,076
Capital receivables	0	0	0	0
Accrued income*	0	5,738	0	6,366
Allowance for other impaired receivables	(55)	(307)	(55)	(307)
Prepayments (non-PFI)	1,705	2,278	119	958
VAT receivable	4	258	4	258
Amount owed by group undertakings	0	0	4,111	4,225
Other receivables	4	263	4	263
Total current receivables	**12,549**	**13,019**	**9,682**	**15,839**
Non-current				
Contract receivables*	909	0	178	0
Trade receivables*	0	761	0	762
Amount owed by group undertakings	0	0	32,470	32,060
Allowance for other impaired receivables	(147)	(157)	(147)	(157)
Total non-current receivables	**762**	**604**	**32,501**	**32,665**
Total receivables	**13,311**	**13,623**	**42,183**	**48,504**

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

17.2 Allowances for credit losses

	Group		Trust	
	31 March 2019 £'000	31 March 2018 £'000	**31 March 2019 £'000**	31 March 2018 £'000
At 1 April	**464**	256	**464**	256
Impact of IFRS 9	**0**	0	**0**	0
Increase in provision	**0**	225	**0**	225
Amounts utilised	**(262)**	63	**(262)**	63
Unused amounts reversed	**0**	(80)	**0**	(80)
At 31 March	**202**	464	**202**	464

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 allowances for creditor losses

	Group		Trust	
	31 March 2019 £'000	31 March 2018 £'000	**31 March 2019 £'000**	31 March 2018 £'000
Ageing of impaired receivables				
0 - 30 days	**3**	0	**3**	0
30 - 60 days	**4**	0	**4**	0
60 - 90 days	**8**	3	**8**	3
90 - 180 days	**40**	304	**40**	304
Over 180 days	**147**	157	**147**	157
	202	464	**202**	464

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 2019	31 March 2018	**31 March 2019**	31 March 2018
	£'000	£'000	**£'000**	£'000
At 1 April	**4,632**	5,426	**675**	1,200
Net change in year	**(1,307)**	(794)	**(432)**	(525)
At 31 March	**3,325**	4,632	**243**	675
Broken down into:				
Cash at commercial banks and in hand	**2,963**	609	**243**	106
Cash with the Government Banking Service	**208**	4,023	**0**	569
Other Investments	**1,850**	0	**0**	0
Total cash and cash equivalents as in SoFP & SoCF	**5,021**	4,632	**243**	675

The group cash balance includes £1.8m held by Symphony healthcare service in an Escrow account. This cash is only accessible under certain conditions.

19 Third Party Assets

The Trust had cash at bank and in hand at 31 March 2019 £1,011 (£2,018 at 31 March 2018) in relation to monies held by the Foundation Trust on behalf of patients.

20 Trade and other payables

	Group		Trust	
	31 March 2019	31 March 2018	**31 March 2019**	31 March 2018
	£'000	£'000	**£'000**	£'000
Amounts falling due within one year:				
Receipts on account	**883**	0	**(28)**	**0**
NHS payables	**2,941**	2,355	**961**	**668**
Trade payables - capital	**1,644**	520	**1,612**	**520**
Other trade payables	**2,547**	5,227	**4,508**	**2,831**
Other payables	**5,128**	5,098	**3,176**	**2,260**
Amount owed to group undertakings	**0**	0	**0**	**622**
Accruals	**7,431**	9,504	**6,601**	**8,206**
NHS Charitable funds payables	**2**	420	**0**	**0**
Total current payables	**20,576**	23,124	**16,830**	**15,107**
Amounts falling due after one year:				
Other trade payables	**132**	131	**0**	**0**
Total non current payables	**132**	131	**0**	**0**
Total payables	**20,708**	**23,255**	**16,830**	**15,107**

Other trade payables include £1,093,647 in respect of outstanding pensions contributions as at 31 March 2019 (2017/18 £986,661).

21 Provisions for Liabilities and Charges

Group and Trust	Legal Claims £'000	Other £'000	Total £'000
At 1 April 2018	913	17	**930**
Arising during the year	6	61	**67**
Change in discount rate	0	0	**0**
Utilised during the year	0	0	**0**
Reversed unused	(13)	(42)	**(55)**
Unwinding of discount	0	0	**0**
At 31 March 2019	**906**	**36**	**942**
Expected timing of cashflows:			
Within 1 year	75	0	**75**
1 - 5 years	228	0	**228**
over 5 years	603	36	**639**
	906	**36**	**942**

£73,724,640 is included in the provisions of the NHS Resolution at 31 March 2019 in respect of clinical negligence liabilities of the Trust, (£59,323,658 for 2017/18).

21.1 Legal Claims

The provision is based on information provided by the NHS Litigation Authority and refers to non-clinical claims against the Trust.

21.2 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 2019	31 Mar 2018	**31 Mar 2019**	31 Mar 2018
	£'000	£'000	**£'000**	£'000
Current				
Department of Health and Social Care	**35,419**	18,143	**35,419**	18,143
Other Loans	**87**	27	**0**	4,601
Intercompany finance lease	**0**	0	**2,465**	2,355
Obligations under finance leases	**162**	147	**162**	148
Total current borrowings	**35,668**	18,317	**38,046**	25,247
Non-current				
Department of Health and Social Care	**44,694**	40,818	**44,694**	40,818
Other Loans	**1,629**	1,072	**0**	0
Intercompany finance lease	**0**	0	**41,311**	43,753
Obligations under finance leases	**1,157**	1,215	**1,320**	1,215
Total non-current borrowings	**47,480**	43,105	**87,325**	85,786

Department of Health and Social Care loans have various interest rates ranging from 0.5% - 1.5% with the first revenue repayment falling due in January 2020 for £17.5m.

The trust also has an intercompany finance lease with Simply Serve Ltd that started on 1 February 2018 with an interest rate of 3.45% totalling £46.1m.

22.1 Investments in Subsidiary Undertakings

	2018/19	2017/18
	£'000	£'000
Shares in subsidiary undertakings	**15,149**	15,149
Loans to subsidiary undertakings > 1 year	**31,709**	32,060
	46,858	47,209
Loans to subsidiary undertakings < 1 year	**898**	1,396
Total	**47,756**	48,605

22.2 Finance Leases

	Group		Trust	
	31 Mar 2019	31 Mar 2018	**31 Mar 2019**	31 Mar 2018
	£'000	£'000	**£'000**	£'000
Gross Leases Liabilities	**1,546**	1,623	**56,232**	67,208
Not later than one year	**206**	197	**2,500**	4,106
Later than one year less than five years	**611**	597	**9,790**	16,766
Later than five years	**728**	829	**43,942**	46,337
Finance charges allocated to future periods	**(226)**	(261)	**(17,646)**	(19,738)
Net lease liabilities	**1,319**	1,362	**38,586**	47,471
Of which is payable				
Not later than one year	**162**	147	**2,487**	2,504
Later than one year less than five years	**491**	472	**11,238**	11,286
Later than five years	**666**	743	**24,861**	33,681
	1,319	1,362	**38,586**	47,471

23 Capital Commitments

There is £265,161 of capital commitments at 31 March 2019 (31 March 2018 £156,962). This is made up of the following:

Women's Hospital Replacement Lift £156,750

Replacement of 1 of 2 lifts in the women's hospital

Other Capital Projects of £108,411 include:

Other commitments relate to electrical works including, replacement of theatre lights, fire compartmentation works in theatres and replacement of life expired plant.

24 Contingent Assets and Liabilities

There were no contingent assets and no contingent liabilities for the year ended 31 March 2019 or for the year ended 31 March 2018.

25 Movements in Public Dividend Capital

Group and Trust	**2018/19**	2017/18
	£'000	£'000
Public dividend capital at 1 April	**42,089**	41,864
New public dividend capital received	**253**	225
Public dividend capital at 31 March	**42,342**	42,089

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 2019, 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:

2018/2019	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000
Dorset County Hospital NHS FT	193	360	33	76
Dorset University Healthcare NHS FT	0	425	7	104
Royal Devon and Exeter NHS FT	669	177	27	108
Gloucestershire Hospitals NHS FT	0	808	0	82
Somerset Partnership NHS FT	3,237	538	332	167
Taunton and Somerset NHS FT	1,303	1,321	430	134
Health Education England	4,120	0	0	0
Dorset CCG	16,131	0	892	211
Somerset CCG	88,032	214	1,954	1,984
Wiltshire CCG	440	0	73	0
NHS England (excluding STF)	25,313	77	1,548	746
NHS England (STF)	22,510	77	205	746
NHS Resolution	0	4,440	0	0
Southwest Pathology Services (JV)	99	1,971	5	0
SPS Facilities (JV)	92	1,799	5	9
Integrated Pathology Services	198	55	19	5
Daycase UK (DCUK)	4,166	6,814	1,183	1,034
Simply Serve LTD	1,442	24,142	44,707	46,775
Symphony Healthcare Services	542	919	0	23

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

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 has submitted 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 2019 Symphony Healthcare Services operates primary care services at locations within Somerset; Ilchester GP practice, Yeovil Health Centre, Buttercross Health Centre, Highbridge Medical Centre, Crewkerne Health Centre, Oaklands Surgery, Hamdon Medical Centre, Wincanton Health Centre, Crewkerne West One Surgery, The Meadows Surgery, Martock Surgery, South Petherton Surgery and Bruton Surgery.

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	88
Net Assets Aquired	(88)
Goodwill	**0**

Daycase UK LLP – Company Number: OC2412071

Registered office – Yeovil District Hospital, Yeovil, Somerset, BA21 4AT

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

A financial instrument is a contract that gives rise to both a financial asset in one entity and a financial liability or equity instrument in another entity. IFRS 7, Financial Instruments: Disclosures, requires 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 financial assets and liabilities of the Trust are generated by day to day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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 NHS Improvement (NHSI) for 2019/20 which plans for a breakeven financial position. The Trust expects to receive non recurrent 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. Quarterly cashflow forecasts are also submitted to the Department of Health to support interim loan applications. Payables are also monitored and managed to ensure all commitments are met.

29.7 Financial Assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	**Carrying Amount 31 Mar 2019**	**Fair Value 31 Mar 2019**	Carrying Amount 31 Mar 2018	Fair Value 31 Mar 2018
	£'000	**£'000**	£'000	£'000
Trade and other recievables	**10,240**	**10,240**	11,085	11,085
Cash at bank	**5,025**	**5,025**	4,634	4,634
	15,265	**15,265**	15,719	15,719

29.8 Financial Liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	**Carrying Amount 31 Mar 2019**	**Fair Value 31 Mar 2019**	Carrying Amount 31 Mar 2018	Fair Value 31 Mar 2018
	£'000	**£'000**	£'000	£'000
Borrowings	**81,829**	**81,829**	60,061	60,061
Finance Lease	**1,319**	**1,319**	1,363	1,363
Other creditors	**15,875**	**15,875**	23,124	23,124
Provisions	**942**	**942**	930	930
	99,965	**99,965**	85,478	85,478

Fair value is not significantly different from book value since, in the calculation of book value, the expected cashflows have been discounted by the Treasury discount rates.