Yeovil Hospital Healthcare

NHS

Annual Report, Quality Account and Annual Accounts 2016/17

Yeovil District Hospital NHS Foundation Trust

Annual Report, Quality Account and Annual Accounts 2016/17

Presented to Parliament pursuant to
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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) 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 delivers services to a population of c200,000 primarily from the rural areas of South Somerset, North and West Dorset and parts of Mendip. Yeovil District Hospital provides outpatient and inpatient consultant services overseen by the Trust's two strategic business units (urgent and elective care) covering the following areas: A&E, acute and general medical services (including inpatient cardiology, gastroenterology, respiratory medicine, elderly care medicine, diabetes & endocrinology) and a full range of medical outpatient services, critical care, trauma and orthopaedics, emergency and general surgery (including urology, ENT, ophthalmology and oral surgery), oncology, diagnostic services, paediatrics, obstetrics 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

Nationally, the NHS is facing unprecedented levels of demand which have been reflected at Yeovil District Hospital. The Trust's primary district of South Somerset has a much higher proportion of residents aged over 65 (21.6%) than the rest of England (16.3%)[1]. This proportion is forecast to increase; estimates suggest that by 2030 there will have been a 43% increase in those aged over 55, compared to a static working population. Within this increase, the number of people aged over 85 is forecast to increase by 120%.[2] Yeovil District Hospital also delivers services to a proportion of residents in North and West Dorset and parts of Mendip where the challenges are broadly similar.

The consequences of this demographic challenge are well known – ever increasing demand on health and social care coupled with a static working age population, and difficulties in recruiting sufficient staff to deal with the increasing demand and the complexity of patient conditions. This pressure is felt across the local health and social care economy. Yeovil District Hospital has developed a clear strategy which aims to tackle this challenge. Key to this is the development of innovative models of care supported by new partnerships and digital technology. In line with the Somerset Sustainability and Transformation Plan (STP) the Trust is on a journey to be part of an Accountable Care System within Somerset. Key to this is the development of increasingly close working with local GP. This is being delivered through the Symphony (Primary and Acute Care) Vanguard programme that has been underway in South Somerset since March 2015. YDH and the South Somerset GPs are one of nine areas across the UK developing and trialling new ways of delivering care through this programme and are widely acknowledged as being one of the most advanced.

[1] Source: Census 2011
[2] Source: ONS 2008-based population estimates

The Trust's vision and strategic objectives were reviewed and approved in October 2016 and can be summarised as follows:

These four strategic objectives are supported by a number of priorities, the operational impact and deliverables for 2017/18 which are described in more detail in the Trust's operational plan for 2017/18 (available on the Trust website) and which are monitored internally through the Board Assurance Framework (BAF).

Underpinning our strategy Yeovil District Hospital has developed a core set of values that are based on our principles of iCARE. We really value and appreciate our staff and recognise that they are our greatest asset. They work tirelessly to provide high quality care for our patients and we are immensely proud of them. Providing high quality clinical care and excellent patient experience are among the Trust's top priorities. The Trust is proud of its iCARE principles, initially developed by nursing staff, which underpin all that is done within the hospital; whether it is providing a life-saving treatment, how staff relate to one another or a warm welcome at reception.

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

The financial impact of the new care models on the Trust was quantified by Oliver Wyman Consultancy and the financial plan that results from this forms the basis of the Trust's plan to address its underlying financial deficit over a five year period. During 2015/16, the Trust has undergone a formal investigation into its financial position by NHS Improvement. This has now concluded and resulted in no formal enforcement action. The investigation recognised that Yeovil District Hospital has the right plans and leadership in place to deliver long-term sustainability for the organisation. It concluded that the majority of the underlying deficit and operational challenges are caused by strategic drivers and factors which are to an extent under the control of Yeovil District Hospital but require wholesale restructuring and partnership with other stakeholders to resolve.

2016/17 Performance Summary

The Board reviewed the areas of focus for quality improvement and developed a Quality Strategy which was approved by the Board in 2015/16 and incorporates national recommendations, including safe staffing levels, and local priorities that reflect patients' needs. In addition, plans to develop and implement models to provide enhanced seven day services, which will be a key enabler to preventing admissions at weekends and facilitating discharge, will improve the experience for patients.

The CQC undertook their planned inspection of the Trust's services 15 – 17 March 2016. The Trust was rated as 'requires improvement' with the report noting the significant operational pressures faced, particularly the emergency department (A&E). The report also highlighted numerous examples of good quality care provided at Yeovil District Hospital and positive feedback from patients, relatives and carers throughout the inspection.

Areas for improvement identified within the inspection included:

- Improving staffing levels in the Emergency Department;
- Requesting an invited review by the Royal College of Paediatrics and Child Health to review the Model of Care for Children and Young People;
- Improving aspects of infection control across the Trust;
- Increasing compliance with staff appraisals;
- Strengthening arrangements for End of Life Care in line with National Standards;
- Improving compliance with risk assessment and care planning for inpatients;
- Increasing 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.

A comprehensive action plan was developed as result of the report and this has further informed our Quality Priorities. This action plan is subject to review and monitoring via the Governance Assurance Committee to ensure progress is evident. A further inspection, using the CQC modified inspection process, is anticipated in 2017.

The Care Quality Commission has not taken enforcement action against Yeovil District Hospital NHS Foundation Trust during 2016/17.

The Trust received positive feedback from patients and as at 31 March 2017, Yeovil District Hospital had a star rating of 4.85 (out of a best possible score of 5) from the I Want Great Care (iWGC) survey.

The key performance highlights for 2016/17 are summarised below:

2016/17 was a year where the demands on Yeovil District Hospital continued to grow. Despite this the Trust performed well against the National operational standards, recovering performance against both the 4-hour A&E waiting time target and Referral to Treatment times (RTT) targets. Both achieved in excess of the National standards during quarter 4. The Trust also maintained strong performance in cancer waiting times and diagnostic waits throughout the year.

Despite the significant and unprecedented operational pressures that the Trust experienced during the year, good performance was maintained, which bears testament to the commitment and dedication of our staff and volunteers. The Trust experienced some difficulty in meeting key performance measures in the first half of the financial year and as a result Yeovil District Hospital agreed short-term action plans and trajectories with the Somerset CCG, NHS England and NHS Improvement in 2016/17 to recover the position for various performance measures throughout the year.

Trust performance remains high across national targets going into 2017/18; the Trust is consistently rated as a high performer both nationally and regionally.

The Trust achieved its financial control total for the year which was set by NHS Improvement. Key to this was the delivery of a £8,102k cost improvement programme, which represents 6% of turnover. Almost 90% of this was delivered recurrently.

Performance Analysis and Assurance

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. Key quality, operational and financial performance metrics are reviewed by the Board on a monthly basis and further scrutinised by the Governance Assurance Committee, the Financial Resilience and Commercial Committee and the Workforce Committee on either a quarterly or monthly 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 on a quarterly basis, they hold us to account along with the Trust's commissioners through contracting arrangements.

Group Entities

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

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

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

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

Symphony Healthcare Services Limited: On 1 April 2016 Symphony Healthcare Services Limited was formed. This joint venture supports the Symphony vanguard programme by offering the option for local GP practices to integrate into a single primary care led operating company. During 2016/17 Symphony Healthcare Services Limited assumed responsibility for three local GP practices: Yeovil Walk-in Centre, Buttercross Surgery, in Somerton, and the Ilchester Surgery. As Symphony Healthcare Services practices, they – and other practices which may choose to integrate in the future – benefit from a larger infrastructure and shared support services such as financial management, IT, HR, and facilities management.

Symphony Healthcare Services also aims to provide a mechanism for spreading the new models of care under development through the Vanguard programme, ensuring that those working in primary care are able to maximise the time that they spend concentrating on the most important thing: providing the best possible care for their patients. At the same time, it enables our hospital to develop better pathways of care in partnership with Primary Care, potentially reducing emergency attendances, and enabling more care to be delivered within local communities, closer to people's homes.

Daycase UK LLP: Daycase UK is a subsidiary of Yeovil District Hospital which was formed in June 2016. It is 70 percent owned by Yeovil District Hospital meaning that it is still very much part of the hospital and the NHS family. It is a partnership with Ambulatory Surgery International (AmSurg), one of the world's best and most experienced providers of day surgery. AmSurg will use their expertise to complement the skills and knowledge of Yeovil District Hospital staff to provide local NHS patients with the latest in surgical procedures and approaches. People will be seen more quickly, treated more efficiently, and discharged more quickly and safely, with services overseen by an NHS team.

Through this joint venture plans are progressing to develop a new, state of the art day surgery unit on the site of the old hospital carpark.

Yeovil Estates Partnership LLP: During 2015/16, the Yeovil Estates Partnership oversaw the development of a new 24-bedded modular ward (figure 1) and in 2016/17 the development of the onsite multi-storey car park which was fully operational in March 2017 (figure 2).

Further information on all group entities can be found within the Trust's Annual Accounts 2016/17.

Figure 1

Figure 2

Going Concern

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

The Department of Health Group Accounting Manual 2016/17 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. In 2016/17, Yeovil District Hospital agreed a deficit control total with NHSI of £15.3m. The Trust agreed a two year annual plan with NHSI which also included a control total for 2017/18 of £13.1m.

However, as Yeovil District Hospital operated with a deficit for 2016/17 and plans a further financial deficit in 2017/18 the Board did have to consider the principle of going concern.

Yeovil District Hospital received a revenue and capital loan from the Department of Health (DoH) in 2016/17, amounting to £17,382million and £1,710million respectively, which enabled the Trust to meet its obligations as they fell due. The 2017/18 financial plans and cash flow forecasts have been prepared on the assumption that further revenue and capital loans amounting to £12,336million and £540,000 respectively will be received from DoH. Discussions to date indicate this funding will be forthcoming and these funds are expected to be sufficient to cover future financial obligations, not including the repayment of the first DoH loan which is due in January 2018 which amounts to £17.5 million.

The Directors have concluded that there is a reasonable expectation the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. Therefore, these accounts have been prepared under a going concern basis as set out in IAS 1.

Summary Statement of Comprehensive Income

	Group	Trust
	2016/17	2016/17
	£m	**£m**
Operating income from continuing operations	146,148	138,331
Operating expenses of continuing operations	(156,720)	(152,231)
Operating loss	**(10,572)**	**(13,900)**
Finance income	31	19
Finance expense – unwinding of discount on provisions and financial liabilities	(885)	(799)
PDC dividends payable	(309)	(309)
Net finance costs	**(1,163)**	**(1,089)**
Share of profit of associate/joint venture	41	0
Deficit for the year	**(11,694)**	**(14,981)**
Revaluation gains and impairment losses – property, plant and equipment	1,436	1,436
Total comprehensive income for the year	**(10,258)**	**(13,553)**

Income

Group		
	2016/17	2015/16
Clinical income	**£'000**	**£'000**
A&E income	5,331	5,047
Elective income	20,103	17,545
Non-elective income	33,761	32,024
Other non-protected clinical income	382	650
Other NHS clinical income	38,287	32,248
Outpatient income	15,685	16,648
Private patient income	2,103	2,293

Clinical income from activities	**115,652**	**106,455**
Other operating income		
Education and training	4,177	4,248
Non-patient care services to other bodies	2,524	4,072
Received from NHS charities	780	470
Research and development	809	806
Resources from NHS charities excluding investment income	4,038	480
Sustainability and Transformation Fund income	5,252	0
Other income	11,966	10,140
Total other operating income	**29,546**	**20,216**
Total operational income	**146,148**	**126,671**

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

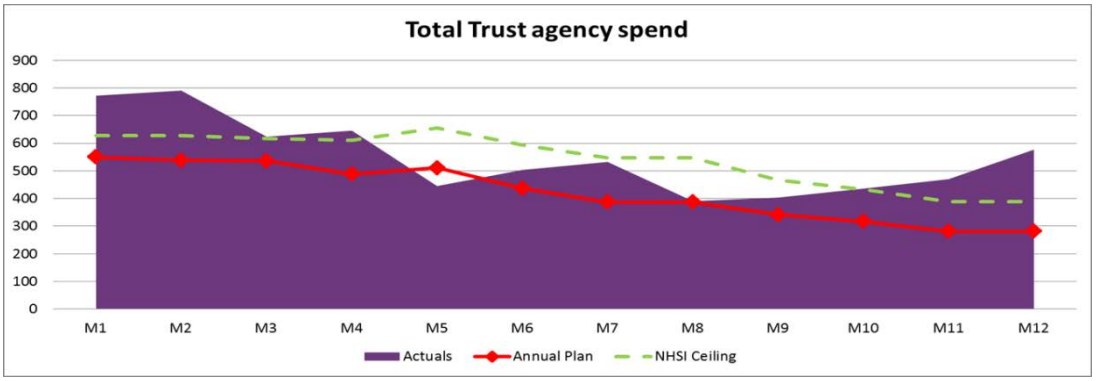
Expenditure

Group		
	2016/17	2015/16
	£'000	**£'000**
Clinical negligence insurance	2,883	2,474
Consultancy costs	377	2,283
Depreciation and amortisation	4,044	3,612
Drug costs	14,282	12,881
Establishment	3,021	3,399
Fees for Audit:		
- Statutory audit	56	82
- Audit related assurance services	11	0
- Charitable funds	7	6
- Other auditor services	128	50
- Internal audit fees	55	50
Increase provisions	25	255
Legal fees	355	439
Losses, ex gratia and special payments	0	10
Loss on disposal of property plant and equipment	0	427
NHS charities expenditure	987	578
Premises	9,167	8,304
Property, plant & equipment impairments	0	0
Purchase of healthcare from non NHS bodies	2,180	1,445
Rentals under operating leases	308	98
Services from:		
- CCGs and NHS England	0	3
- NHS Foundation Trusts	3,539	2,415
- NHS trusts	0	76
Staff costs:		
- Executive directors'	1,471	1,248

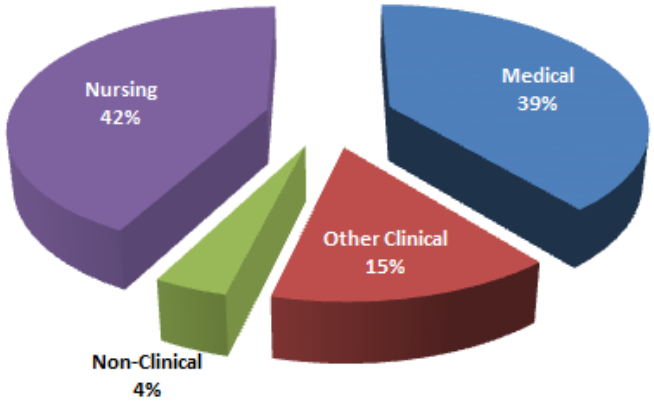
- Other staff costs	94,509	86,790
- Redundancy costs	1,054	465
- Non-executive director costs	104	105
Supplies and services (excluding drug costs)		
- Clinical	13,368	12,977
- General	2,405	2,228
Training	590	693
Transport	542	420
Other	464	599
	156,720	**144,412**

Agency Staffing

During 2016/17 the Trust worked intensively with support from NHS Improvement to reduce the use of agency staff. A full action plan was developed and implemented which included the introduction of a series of controls and measures to help reduce dependency on temporary staff.



The reduction in agency spend through the year is set out above. The Trust was set an agency cap ceiling by NHS Improvement of £6,498k for the year. Spend during the year totalled £6,593k which represented a reduction of £2,588k on spend in 2015/16. This was £95k above the ceiling. The make-up of this expenditure is shown below:



Medical staffing is the most challenging area with locums continuing to demand high pay rates. However, there has been some success in filling vacancies which has reduced our demand for locums. 18 Consultant and Middle Grade doctors were appointed during 2016/17. In addition, Yeovil District Hospital has filled more shifts through the Trust's bank staff pool with the fill rate for medical staffing reaching a high of 80% in November 2016. The fill rate averaged 61% across the year.

Another area of high agency spend is nursing, caused by a high vacancy rate. Following a successful recruitment campaign in the Philippines there are plans to significantly reduce this over the coming year which will result in a further reduction in agency spend. Nurse bank fill rates have also been significantly increased, having a positive impact on our agency spend. Improvements during the year are as follows:

- HCA fill rate moved from 34% in April 2016 to a high of 99% in March 2017
- RGN fill rate moved from 26% in April 2016 to a high of 58% in March 2017

Capital Investment

£5.4m was invested in capital developments in 2016/17, which included spend on medical and radiology equipment, TrakCare (electronic patient record system) development, general site improvements, IT upgrades and construction works within Special Care Baby Unit (SCBU), main kitchen, outpatients and the emergency department.

Cashflow Statement

	Group	
	2016/17	2015/16
	£'000	£'000
Cash flows from operating activities		
Operating deficit	**(11,522)**	(17,314)
Non-cash income and expense:		
Depreciation and amortisation	**4,044**	3,612
Net impairments and reversals of impairments	**788**	0
Income recognised in respect of capital donations	**(780)**	0
(Increase)/decrease in receivables and other assets	**(3,685)**	(284)
(Increase)/decrease in inventories	**75**	34
Increase/(decrease) in payables and other liabilities	**(1,440)**	3,876
Increase/(decrease) in provisions	**120**	(43)
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows	**449**	0
Other movements in operating cashflows	**950**	0
Net cash generated from operations	**(11,001)**	(9,962)
Cash flows from investing activities		
Interest received	**19**	27
Payments to acquire intangible assets	**(1,603)**	(1,826)
Payments to acquire tangible fixed assets	**(6,971)**	(7,235)
Sale of property, plant and equipment	**52**	0
Receipt of cash donations to purchase capital assets	**780**	0
Net cash used in investing activities	**(7,723)**	(9,034)
Cash flows from financing activities		
Public Dividend Capital received	**41**	0

Loans received from Department of Health	**18,745**	23,000
Movements on other loans	**1,493**	0
Interest paid on loans	**(750)**	(79)
Loans repaid - including finance lease capital	**(155)**	(155)
Interest element of finance lease	**(68)**	(69)
Other capital movements	**(64)**	(196)
PDC dividends paid	**(272)**	(905)
Charitable fund financing activities	**12**	3
Net cash used in financing activities	**18,982**	21,599
Increase / (decrease) in cash and cash equivalents	**258**	2,603
Cash and cash equivalents at 1 April	**5,168**	2,565
Cash and cash equivalents at 31 March	**5,426**	5,168

Summary Statement of Financial Position

	Group	Group
	2016/17	2015/16
	£m	**£m**
Non-current assets	62.06	58.48
Current assets	16.28	12.36
Current liabilities	(33.79)	(18.22)
Total assets less current liabilities	**44.58**	**52.62**
Non-current liabilities	(27.73)	(25.55)
Total assets employed	**16.84**	**27.07**
Total taxpayers equity	**16.84**	**27.07**

Cost Improvement Plans (CIP)

Yeovil District Hospital delivered a very challenging cost improvement plan target during 2016/17. In year savings of £8,102k were delivered. This was £116k ahead of the plan of £7,987k and continues to implement initiatives to remove waste and improve the efficiency of services. 88% of cost improvement plans savings were recurrent and represent approximately 6% of turnover. This level of delivery represents a significant increase in previous years. The profile of delivery of the 2016/17 CIP is shown below:

Environmental Sustainability

It is recognised that the NHS has a role to play in reducing the UK's carbon dioxide emissions. The operation of Yeovil District Hospital NHS Foundation Trust involves many activities which have an impact on the environment. These include the use of energy and water, the production and handling of waste and the use of natural resources.

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

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

Energy Management

The Trust purchases its energy through the Crown Commercial Services Framework which gives the Trust access to energy saving advice and engineering best practice. The ongoing Energy Performance Contract (EPC) with Cynergin Ltd continues to deliver the budgeted savings for the Trust, despite some reliability issues with one of the Combined Heat and Power Plants (CHPs).

The Trust continues to perform better than its peer median and ERIC benchmark values for Cost of Energy and Energy Use per Floor Area.

The Trust has continued to invest in energy saving plant and equipment in the period including new Air Handling plant for theatres and main circulation areas and LED lighting in all refurbishment projects.

Waste Management

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

Yeovil District Hospital is actively reducing waste by ensuring:

- All dry mixed recycling products, including paper, hand towels, cardboard, plastic bottled and metal cans is bulk compacted and sorted into its constituent parts for recycling
- Soft clinical waste is sent for alternative treatment (not incineration) and is then processed as refused derived fuel.
- Reducing packaging used for hard clinical waste, reducing waste sent for incineration
- Organic waste from our grounds and gardens, such as grass cuttings is sent for composting and re-use
- Electronic and electrical equipment waste is sent for recovery and all parts are recycled where possible

Equality, Diversity and Human Rights

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

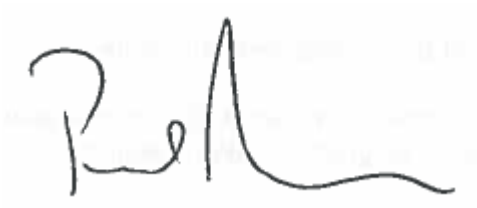
- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share protected characteristics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

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

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

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

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



Paul Mears, Chief Executive, 26 May 2017

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.

YD Yeovil District Hospital H has applied the principles of 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 Board and Council of Governors exercise their functions as set out in the Trust's constitutional documents, relevant legislation and the regulatory framework. A register of interests for the Council of Governors and the Board is kept by Yeovil District Hospital and reviewed at least annually. From November 2016, the register for Board members is presented at the Board of Directors meeting on a monthly basis. The registers are also available, on request, from the Company Secretary and the list of interests of the Board is set out from page 26.

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

The Board may appoint committees consisting wholly or partly of directors, or wholly or partly of persons who are not directors. The committees of the Board are: Audit Committee, Governance Assurance Committee, Financial Resilience and Commercial Committee, Workforce Committee, Trustees (Charitable Funds) 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 the amendment to it, contained within the 2012 Act, expanded, clarified and added to them.

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 2016/17 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 2016/17, 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, approved the appointment of a new non-executive director and approved the reappointment of a non-executive director. To comply with their role to hold the non-executive directors to account, the Council of Governors regularly met with and requested updates from the non-executive directors and attended meetings of the Board and its assurance committees.

In the event of dispute between the Council of Governors and the Board, in the first instance the Chairman shall seek to resolve it (on advice from the Company Secretary and/or Senior Independent Director and such other guidance as the Chairman may see fit to obtain). If the Chairman is unable to address the dispute, he shall appoint a special committee comprising equal numbers of directors and governors to consider the circumstances and to make recommendations to the Council of Governors and the Board. If the recommendations (if any) of the special joint committee are unsuccessful, the Chairman may refer the dispute back to an external mediator appointed by an organisation selected by him. There were no disputes between the Council of Governors and the Board during 2016/17.

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.

Internal 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.

The Trust's internal auditors are BDO and they review levels of assurance on the adequacy of internal control arrangements, including risk management and governance. The Trust's external auditors are KPMG who provide the Trust's statutory audit services. KPMG also undertakes advisory services as and when required, predominately relating to VAT liaison services. During 2016/17, KPMG reviewed whether their general procedures support their independence and objectivity, including any matters related to the provision of non-audit services, and positive affirmation has been presented to the Audit Committee.

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

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

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

- Property valuation
- NHS and non-NHS income
- Management override of controls

The Audit Committee also considered the value for money risks identified by external audit identified from a risk assessment process.

Governors and Membership Information

The Council of Governors meets quarterly and comprises 13 elected public governors, 5 elected staff governors and 5 appointed governors from partner organisations. The 13 public governors are elected by members who live in the Trust's constituencies. Elected governors (public and staff) are usually appointed for three year terms. There is no time limitation for appointed members. John Park was lead governor during 2016/17 up until 31 January 2017 whereby Alison Whitman was appointed as lead governor following John Park's resignation.

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 2017, membership of the public constituency stood at 7,428, a small decrease compared to the previous year. Public membership equates to approximately 5% of the Trust's South Somerset catchment area. As at 31 March 2017, membership of the staff constituency rose to 2,285, a slight increase on the previous year.

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

Public Membership

Constituency	Greater Yeovil	South Somerset (S&W)	South Somerset (N&E)	Dorset	Mendip	Rest of Somerset & England	Totals
At 31 March 2017	2,365	1,634	1,789	915	552	175	7,428

Staff Membership

Staff Membership	2016/17
At 31 March 2017	2,285

Elected Governors – Public Constituency

Name	Constituency	Date Elected	Duration of Term of Office (Years)	Attendance at Council of Governor Meetings 16/17
Mary Belcher	Greater Yeovil	01/06/2016	1	3/4
Philip Tyrrell	Greater Yeovil	01/06/2015	2	3/4
John Webster	Greater Yeovil	01/06/2014	3	4/4
Tony Robinson	South Somerset (South and West)	01/06/2016	1	3/4
Sue Bulley	South Somerset (South and West)	01/09/2014	3	4/4
John Tricker	South Somerset (South and West)	01/09/2014	3	3/4
Jane Gifford	South Somerset (South and West)	01/06/2012 01/06/2013	1 3	0/0
Sue Brown	South Somerset (North and East)	01/06/2015	2	4/4
Monica Denny	South Somerset (North and East)	01/09/2014	3	0/0
John Hawkins*	South Somerset (North and East)	01/09/2014	3	3/3
John Park*	Dorset	01/06/2009 01/06/2012 01/06/2015	3 3 2	4/4
Ian Fawcett	Dorset	01/06/2007 01/06/2010 01/06/2013	3 3 3	0/0
Jeremy Hughes	Dorset	01/06/2016	1	2/4

Hala Hall	Mendip	01/06/2014	3	3/4
Alison Whitman	Rest of Somerset and England	01/06/2014	3	4/4

*John Park resigned as a public governor on 31 March 2017. John Hawkins resigned as public governor on 28 February 2017. Both vacancies were held until the spring governor elections.

Elected Governors - Staff Constituency

Name	Constituency	Date Elected	Duration of Term of Office (Years)	Attendance at Council of Governor Meetings 16/17
Michael Fernando*	Staff	01/06/2012 01/06/2015	3 2	3/4
Paul Porter	Staff	01/06/2013 01/06/2016	3 1	4/4
Judith Lindsay-Clark	Staff	01/06/2014	3	4/4
Fiona Rooke	Staff	01/06/2016	1	4/4
Yvonne Thorne	Staff	01/06/2015	3	2/4
Nicholas Craw*	Staff	01/06/2015	1	0/0
Julia Hendrie	Staff	01/06/2014	2	0/0

*There were governor elections in the staff and public constituencies in the spring/summer of 2016. Nicholas Craw was elected as a staff governor in place of Julia Hendrie who resigned part way through her three year term and as such only served a one year term. The post was re-elected in the spring of 2016 and won by Fiona Rooke.

Appointed Governors

Name	Stakeholder Organisation	Attendance at Council of Governor Meetings 16/17
David Recardo	South Somerset District Council	4/4
Rob Childs	Dorset CCG	0/4
Lou Evans	Somerset CCG	1/4
Jane Lock	Somerset County Council	2/4
Peter Shorland	Dorset County Council	2/4

Membership Strategy and Representation

YDH recognises the importance of having a strong and representative membership. With approximately 7,500 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 and those from local black, minority and ethnic communities. YDH has a membership coordinator (Assistant Company Secretary) who works with the communications team to develop and implement the membership strategy. In 2016/17, the governors agreed the implementation of 'Governor Surgeries' within the outpatient department for direct feedback from members and patients and to assist in the recruitment of Foundation Trust members.

Public Membership: Gender

	Gender	31/03/17
Public	Male	2,872 (38.66%)
	Female	4,529 (60.97%)
	Unspecified	27 (0.36%)

Staff Membership: Gender

	Gender	31/03/17
Staff	Male	508 (22.23%)
	Female	1,777 (77.77%)
	Unspecified	0 (0%)

Public Membership Representation

	White	Mixed / Multiple Ethnic Groups	Asian / Asian British	Black / Black British	Other Ethnic Group	Unknown
Public						
31/03/17	7,036 (94.72%)	17 (0.23%)	74 (1.00%)	21 (0.28%)	6 (0.08%)	271 (3.69%)

Staff Membership Representation

	White	Mixed / Multiple Ethnic Groups	Asian / Asian British	Black / Black British	Other Ethnic Group	Unknown
Staff						
31/03/17	1,870 (81.84%)	16 (0.70%)	169 (7.31%)	17 (0.74%)	44 (1.93%)	2171 (7.48%)

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

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

Yeovil District Hospital holds events, produces marketing and publicity material and distributes a hospital newsletter to all members either in hard copy form or by email. Governors undertake opportunistic recruitment and communication within their communities.

Contact Information for Members

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

Directors Report

Statement of Disclosure to the Auditors

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

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

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

Income Disclosures

The income received from the provision of goods and services for other purposes other than providing healthcare is less than that received for providing healthcare. The other income received enables us 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.

	2016/17 Number	2016/17 £'000	2015/16 Number	2015/16 £'000
Total Non-NHS trade invoices paid in year	53,051	77,444	59,823	64,382
Total Non-NHS trade invoices paid within target	49,041	71,582	56,999	61,797
Percentage of non-NHS trade invoices paid within target	92%	92%	95%	96%
Total NHS trade invoices paid in year	1,926	10,551	2,007	8,812
Total NHS trade invoices paid within target	1,800	10,076	1,888	8,727
Percentage of NHS trade invoices paid within target	93%	96%	94%	99%

Quality Governance

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

The Board

The membership, skills and expertise of the Board during 2016/17, together with attendance at meetings, the commitments of the Chair, the length of appointment of the non-executive directors, and any declarations of interests, were as follows:

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

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. Following a competitive recruitment process (for which consultancy services were not engaged), he was appointed as the Trust Chairman on 4 January 2016.

Paul von der Heyde is a chartered accountant and was previously in practice in London for almost 30 years specialising in business development for a variety of clients. He then spent 11 years as Chief Executive of Kinnarps in the UK.

He is Deputy Chairman of easipetcare Limited, Trustee and Advisor of Howlands Furniture Group, Non-Executive Director of Silvatherm Energy Limited, Non-Executive Director of the Psoriasis and Psoriatic Arthritis Alliance and a Lecturer in Finance and Strategy with the ICMA Centre, Henly Business School, and University of Reading.

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

Maurice Dunster+ — Non-Executive Director

Maurice Dunster joined the Trust Board in June 2012.

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

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

Julian Grazebrook+* Non-Executive Director

Julian Grazebrook joined the Trust Board in September 2010.

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

Board Meeting: 9/11
Audit Committee Attendance: 5/5
Board Remuneration Committee Attendance: 3/4

Jane Henderson+* Non-Executive Director

Jane Henderson joined the Trust Board in June 2013.

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

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

Mark Saxton+ Non-Executive Director

Mark Saxton joined the Trust Board in June 2012.

Mark Saxton is a UK chartered director and a fellow of the institute of directors. He was appointed having held senior management positions in HR and general management in FTSE and NYSE listed companies, both internationally and in the UK. He runs an executive coaching and outplacement practice and has served on Boards in both charity and commercial enterprises. He is Chair of the Workforce Committee. He was appointed as Chair of the Board Remuneration Committee from January 2016.

Board Attendance: 10/11
Board Remuneration Committee Attendance: 3/4

Caroline Moore+*	Non-Executive Director

Caroline Moore joined the Trust Board in September 2016.

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

Board Attendance: 7/7

Paul Mears	Chief Executive

Paul Mears joined the Trust Board in May 2012.

Paul Mears joined YDH from his role of Chief Operating Officer at South Devon Healthcare NHS Foundation Trust where he had been since 2009. Previously he was Director of Operations at Torbay Care Trust where he was responsible for integrating community health and social care services in one of the leading examples of integrated care in the UK. Paul joined the NHS through the Gateway Leadership Programme having previously worked in commercial management for British Airways and Eurostar. He is a Director of the Yeovil Strategic Estates Partner Board, which is the partnership between YDH and InterservePrime, SPS LLP, Symphony Healthcare Limited, Yeovil Property Operating Company Limited and Wellchester Innovation Limited.

Board Attendance: 9/11

Jon Howes	Deputy Chief Executive (up to 31 November 2016)

Jon Howes joined the Trust Board in September 2012.

Jon Howes assumed the role of Medical Director in 2010 after 6 years' service with the Trust as a consultant in anaesthesia and intensive care and as lead consultant in intensive care. Jon was appointed as Deputy Chief Executive in September 2012. In March 2014, Jon stepped down as Medical Director so he could dedicate more time on the strategic role of Deputy Chief Executive. In December 2016, Jon took up the role of Medical Director of Daycase UK and stood down as Deputy Chief Executive.

Board Attendance: 6/7

Tim Scull — Medical Director

Tim Scull joined the Trust Board in March 2014.

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

Board Attendance: 11/11

Helen Ryan — Director of Nursing and Clinical Governance

Helen Ryan joined the Trust Board in August 2012.

Helen Ryan joined YDH as sister in charge of the intensive care unit in 1993. She became nurse consultant in intensive care in 2001 and was a staff representative on the Council of Governors for 6 years. Helen trained at Southmead Hospital in Bristol and worked at St Thomas' Hospital in London before spending 8 years in the Royal Air Force. Helen was appointed as Interim Director in August 2012 and substantively as Director of Nursing and Clinical Governance in January 2014. Helen retired on 31 March 2017.

Board Attendance: 11/11

Timothy Newman — Chief Finance & Commercial Officer

Tim Newman joined the Trust Board in February 2013.

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

Board Attendance: 8/11

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

Jonathan Higman — Director of Strategic Development

Jonathan Higman joined the Trust Board in January 2009.

Jonathan Higman started his role as the Director of Strategic Development in June 2015. Previously, Jonathan was the Director of Urgent Care and Long Term Conditions and Director of Operations at the Trust. Jonathan graduated from the University of Reading in 1993 and has 17 years' experience working in a variety of roles in both hospitals and service planning across the NHS in the South West and South East.

Board Attendance: 9/11

Simon Sethi — Director of Urgent Care and Long Term Conditions

Simon Sethi joined the Trust Board in June 2015.

Simon Sethi joined YDH from Gloucestershire CCG where he was Programme Director for Urgent Care and Deputy Director of Commissioning responsible for commissioning of ambulance and hospital services. He was appointed as interim Director of Urgent Care and Long Term Conditions in June 2015. He was appointed substantively in December 2015. 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.

Board Attendance: 9/11

Shelagh Meldrum — Director of Elective Care

Shelagh Meldrum joined the Trust Board in February 2016.

Shelagh Meldrum joined YDH with a background in nursing and as a clinical services leader in both the NHS and private facilities. Shelagh began her career in the NHS as a senior nurse working in acute medicine, and subsequently as a senior specialist nurse in neurology. She later became a clinical services lead, managing the six departments which formed the directorate of specialist medicine. Following a 14-year career in the NHS Shelagh worked as Head of Clinical Services in various independent healthcare facilities. For the last seven years she has 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. She is a share-holding partner in Circle Health and her husband worked for Circle Health in-year.

Board Attendance: 9/11

Mandy Seymour-Hanbury Managing Director of Symphony Healthcare Services

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

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

Board Attendance: 8/11

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

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

NHS foundation trusts are subject to the recommendations of Monitor's *NHS Foundation Trust Code of Governance* (modelled on best practice UK governance principles) and the *Well-Led Framework for Governance Reviews*, which encourage Boards to conduct a formal evaluation of their own performance and that of its committees and directors. Accordingly, and as reported last year, during 2013/14, Ernst & Young LLP was commissioned to undertake a review of the performance and effectiveness of the Trust's Board and its committees. The recommendations were presented to the Board in March 2014. The overall findings were positive in acknowledging the Board and its committees were functioning well, although they identified some opportunities for improvement. An action plan containing the key recommendations was implemented in 2014/15 and into 2015/16. A review of the governance structure was also undertaken in 2013/14 by the internal auditors. Overall, the review identified the governance processes at Yeovil District Hospital were essentially robust and that the chief components of good governance (such as strong leadership, challenge by non-executive directors and focus on risk) were in place. However, the review also identified that the arrangements were in need of updating. As a result, in September 2014, a revised governance structure was approved by the Board. Further information is contained within the annual governance statement.

Yeovil District Hospital has been selected to be one of the pilot sites for the joint NHS Improvement and Care Quality Commission's inspections of the well-led domain as well as the use of resources. This review will be undertaken in June 2017 and the results will be presented to the Board following this.

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 26. In 2016/17, the Committee was chaired by Mark Saxton, Non-Executive Director. The Chief Executive, Company Secretary, Medical Director and Associate Director of Human Resources and Organisational Development attended the Remuneration Committee during 2016/17 to give advice as required.

With the exception of the Chief Executive, directors, doctors, and some key functional roles, all staff are remunerated in accordance with the NHS National Pay Structure, Agenda for Change. The Chief Executive and all executive directors are employed on substantive contracts under the very senior managers pay scheme. Three 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, 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.

In line with a previous Ernest Young review of the effectiveness of the Trust Board, the Remuneration Committee considers that the Board has the appropriate composition and skill mix to meet the strategic objectives of the organisation and sets executive director remuneration to reflect this position. In line with the Trust's strategic priorities, objectives are set for the Chief Executive and executive directors annually and performance is assessed through a formal appraisal process. This is reported annually to the Committee. Pension arrangements for the Chief Executive and executive directors are in accordance with the NHS Pension Scheme. The accounting policies for pensions and other relevant benefits are set out in the accounts.

During 2016/17, following Helen Ryan, Director of Nursing's planned retirement and the appointment of Shelagh Meldrum into the role alongside her existing Director of Elective Care responsibilities, the Remuneration Committee reviewed the salary of Shelagh Meldrum.

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 2016/17 was £185,000 to £190,000 (2015/16 £185,000 to £190,000).

This was 6.50 times (2015/16 - 6.70 times) the median remuneration of the workforce which was £28,479 (2015/16 - £27,587).

In 2016/17, two employees received remuneration in excess of the highest paid director (2015/16 - one). Remuneration ranged from £193,000 to £207,000 (2014/15 £193,000 to £195,000). The employees receiving remuneration in excess of the highest paid director are medical consultants.

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

During 2016/17 there was a public sector inflationary pay award of 1%. Where employees weren't at the top of their pay scale contractual incremental pay increases were applied. There was a slight increase in median pay between 2016/17 and 2015/16 due to incremental points of leavers and starters and the inflationary pay award.

Expenses of the Governors and Directors

The Trust has a policy on the payment of expenses which governs all staff, including directors, governors and volunteers. During 2016/17 the expenses paid to members of the Board and directors attending the Board totalled £48,894. During the same period the expenses paid to the members of the Council of Governors totalled £1,716. The combined sum for expenses was £50,610, which compares to £42,000 for 2015/16.

Salary and Pension Entitlements of Senior Managers 2016/17

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

Notes
The salaries of J Howes and T Scull include pay for their clinical and non-clinical responsibilities.

Salary and Pension Entitlements of Senior Managers 2015/16

Name and Title		2015/16					
		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 Wyman CBE	Chairman	30 - 35	300	0	0		30 - 35
J Grazebrook	Non-Executive Director	10 - 15	0	0	0		10 - 15
M Dunster	Non-Executive Director	10 - 15	0	0	0		10 - 15
M Saxton	Non-Executive Director	10 - 15	0	0	0		10 - 15
P von der Heyde	Non-Executive Director/ Chairman	15 - 20	0	0	0		15 - 20
J Henderson	Non-Executive Director	10 - 15	0	0	0		10 - 15
P Mears	Chief Executive	185 - 190	400	0	0	45 - 47.5	230 - 235
Dr L J Howes	Deputy Chief Executive	185 - 190	300	0	0	22.5 - 25	210 -215
T Newman	Chief Finance and Commercial Officer	165 - 170	2,300	0	0	5 - 7.5	175 - 180
H Ryan	Director of Nursing and Clinical Governance	90 - 95	0	0	0	15 - 17.5	105 - 110
J Higman	Director of Strategic Development	90 - 95	400	0	0	25 - 27.5	115 -120
S Sethi	Director of Urgent Care and Long Term Conditions	70 - 75	2,800	0		47.5 - 50	120 - 125
Dr T Scull	Medical Director	150 - 155	400	0	0	17.5 - 20	170 - 175
L Allen	Director of Elective Care	85 - 90	0	0	0	22.5 - 25	110 - 115
M Seymour-Hanbury	Chief Officer for Integrated Care	45 - 50	0	0	0	0	45 - 50
S Meldrum	Director of Elective Care	10 - 15	500	0	0	135 - 137.5	145 - 150

Notes
P Wyman left the trust in Jan 16.
L Allen left the trust in Nov 15, her salary includes a golden hello compensation for loss of office between £25,000 - £30,000.
P von der Heyde was appointed Chairman in Jan 16.
S Sethi joined the organisation in June 15.
M Seymour-Hanbury joined the organisation in Nov 15.
S Meldrum joined the organisation in Feb 16.
The salaries of J Howes and T Scull include pay for their clinical and non-clinical responsibilities.

Pension Benefits of Senior Managers 2016/17

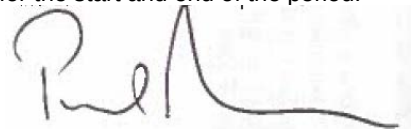
Name and Title		Real increase in pension at pension age (bands £2,500)	Real increase in pension lump sum at pension age (bands £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
P Mears	Chief Executive	5 - 7.5	0 - 2.5	30 - 35	75 - 80	386	98	484	26
Dr L J Howes	Medical Director	7.5 - 10	5 - 7.5	60 - 65	165 - 170	944	172	1,116	24
T Newman	Chief Finance and Commercial Officer	5 - 7.5	0 - 2.5	15 - 20	0 - 5	142	88	230	24
H Ryan	Director of Nursing and Clinical Governance	0 - 2.5	2.5 - 5	35 - 40	105 - 110	735	46	781	13
J Higman	Director of Strategic Development	0 - 2.5	0 - 2.5	25 - 30	65 - 70	357	35	392	13
I Sethi	Director of Urgent Care and Long Term Conditions	2.5 - 5	0 - 2.5	10 - 15	30 - 35	111	31	142	13
Dr T Scull	Medical Director	2.5 - 5	7.5 - 10	60 - 65	185 - 190	1,193	88	1,282	21

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.

Pension Benefits of Senior Managers 2015/16

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 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
P Mears	Chief Executive	0 - 2.5	5 - 7.5	25 - 30	75 - 80	351	31	386	26
Dr L J Howes	Medical Director	0 - 2.5	2.5 - 5	50 - 55	160 - 165	909	24	944	25
T Newman	Chief Finance and Commercial Officer	0 - 2.5	0 - 2.5	10 - 15	0 - 5	134	7	142	24
H Ryan	Director of Nursing and Clinical Governance	0 - 2.5	0 - 2.5	30 - 35	100 - 105	701	25	735	13
J Higman	Director of Strategic Development	0 - 2.5	0	20 - 25	65 - 70	340	13	357	13
I Sethi	Director of Urgent Care and Long Term Conditions	0 - 2.5	0	10 - 15	30 - 35	85	6	111	11
Dr T Scull	Medical Director	0 - 2.5	0	60 - 65	180 - 185	1,156	24	1,193	21
L Allen	Director of Elective Care	0 - 2.5	0	5 - 10	10 - 15	91	3	104	9
S Meldrum	Director of Elective Care	0 - 2.5	0	5 - 10	15 - 20	2	24	98	2

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.



Paul Mears, Chief Executive, 26 May 2017

Staff Report

Our people never cease to amaze us. 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; we are immensely proud of them. We do not take our people for granted and we work hard to engage them in everything we do. It is the Trust's ambition to be one of the best trusts to work for; as such we are continuously looking for new ways to improve staff members' health and general wellbeing.

We employ the following people (as at 31 March 2017):

Headcount (Excluding Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	3	5	8
Non Executives & Chairman	2	4	6
Other Senior Managers	31	16	47
All other employees	1692	476	2168
Grand Total	**1728**	**501**	**2229**

Headcount (Including Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	3	5	8
Non Executives & Chairman	2	4	6
Other Senior Managers	31	16	47
All other employees	2072	596	2668
Grand Total	**2108**	**622**	**2730**

Full-Time Equivalent (Excluding Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	3.00	5.00	8.00
Non Executives & Chairman	2.00	4.00	6.00
Other Senior Managers	28.64	15.80	44.44
All other employees	1377.07	447.72	1824.79
Grand Total	**1408.71**	**472.52**	**1883.23**

Full-Time Equivalent (Including Bank Employees)			
	Female	**Male**	**Grand Total**
Directors & Chief Executive	2.00	5.00	7.00
Non Executives & Chairman	2.00	4.00	6.00
Other Senior Managers	28.64	15.80	44.44
All other employees	1377.07	447.72	1824.79
Grand Total	**1409.71**	**472.52**	**1882.23**

The average number of employees employed by Yeovil District Hospital:

Average Number of Employees (Full-Time Equivalent)	2016/17			2015/16
	Permanent	Other	Total	Total
Medical and dental	249	5	254	227
Administration and estates	552	3	555	537
Healthcare assistants and other support staff	535	27	562	512
Nursing, midwifery and health visiting staff	589	42	631	628
Scientific, therapeutic and technical staff	145	1	146	161
Total Average Numbers	**2070**	**78**	**2148**	**2065**

Staff Costs

Group	2016/17			2015/16
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	72557	837	73434	66105
Social security costs	6618	0	6618	4796
Employer's contributions to NHS pensions	8411	0	8411	7916
Agency/contract staff	0	7517	7517	9181
NHS charitable funds staff	40	0	0	40
Termination benefits	1054	0	0	465
Total staff costs	88680	8354	97034	88503

Sickness Absence Data

Our sickness absence rate was 3.02%, against a target of 3% (as at 30 December 2016). We have worked hard to reduce sickness and our score compares favourably with national and regional rates of 4.55% and 4.62% respectively. We are also increasing our focus on keeping our people well and we are developing a number of programmes to assist in this. We provide resilience and mindfulness programmes and have put in place a number of 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, we are statutorily required to ensure that equality, diversity and human rights are embedded into its our 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, we have taken part in numerous initiatives and embedded good practice within the organisation. We are also a disability symbol user. To ensure equality of opportunity, the Trust supports disabled persons working at the hospital to access learning and development opportunities. This includes meeting with them individually and putting in place a tailored support plan. From this, additional requirements to support their learning may be identified such as additional time and/or access to resources. For medical and nursing students, any support needs are aligned with those of the university to which they are affiliated. However, we want to go above and beyond what is statutorily required. We want to be an organisation that not only embraces equality and diversity, but embeds fairness and inclusion into everything that we do.

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 we are 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.

We have a 'Freedom to Speak up Guardian', and a simple accessible process for raising concerns. We have also increased the use of social media such as blogs and Twitter as a mechanism of interaction, in addition to regular team meetings, and monthly meetings for all staff and managers. Weekly newsletters are also produced which include details of key quality improvement information (such as learning from incidents and complaints).

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

Health and Safety

Yeovil District Hospital has continued to improve arrangements around fire safety during 2016/17 with the changeover of the fire alarm system that aims to reduce false alarms and improves reliability from the old unsupported system. Working with the Fire and Emergency Services, Yeovil District Hospital carried out a series of evacuation exercises practicing high rise evacuation procedures and carried out a multiagency evacuation planning exercise that has led to improvements in evacuation planning procedures. Physical improvements have taken place in passive and preventative fire safety arrangements. This includes upgrading fire compartments to prevent potential fire and smoke from spreading and installing suppressions systems in the kitchen to prevent cooking fires from developing.

The Local Security Management Specialist (LSMS) has combined with the Dementia lead to raise staff awareness on how to minimise conflict with patients who have forms of cognitive impairment. Conflict resolution training has also been targeted at the highest reporting incident areas of violence and aggression to support staff to enable them to reduce conflict.

Further improvements in CCTV monitoring and providing secure access to facilities has increased patient and staff safety and working with the local police services Yeovil District Hospital has been able to improve procedures when patients go missing to prevent harm.

Targeted manual handling training and improvements in handling equipment to hoist and weigh patients have been made in response to the needs of staff and patients. Safety auditing processes have been reviewed to target risk areas with the aim of risk reduction and a programme of training fire wardens and first aiders has seen an increase in the numbers of staff involved with maintaining safe workplaces. Lone working has been a particular area where systems used for peripatetic workers have been introduced to support staff working and travelling in the community.

Occupational Health

We have 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.

We have also put 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 using a website with comprehensive information and guidance.

Countering Fraud and Corruption

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

Engaging our People

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

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

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 six categories such as the Lifetime Achievement Award and the Rising Star Award.

The effects of our work on staff engagement are seen in the encouraging results of our staff survey, hitting our flu vaccination target and achieving our control total. Good staff engagement is and will remain an intrinsic part of how Yeovil Hospital achieves its ambitious goals in 2017/2018. We will continue to develop by building new communication channels, for example livestreaming staff briefings on Facebook and running focus weeks on initiatives such as red and green days.

Staff Survey

The 2016 Staff Survey has shown improvements in many areas and whilst there is a lot more to do, we are moving in the right direction and the results are encouraging. Our response rate was 64% (2015/16 - 61%).

The results show us that:

- We are getting better at managing our people;
- People feel they are supported by our managers;
- Managers act on feedback;
- People feel increasingly valued;
- Opportunities for flexible working are good;
- We take an interest in the health and wellbeing of our people.

The number of staff who recommend Yeovil District Hospital as a place to work has also improved since last year, and we are above average for acute trusts.

However, we are aware that in some areas there is a need for improvement, and this is with regard to the quality of care staff are able to offer, low appraisal rates, opportunities for promotion, effectiveness of reporting procedures, and the levels of physical violence against staff by patients.

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

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

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

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

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

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

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

- agreeing a new staff engagement plan with staff representatives to ensure we fully involve and engage our people in everything we do;
- building on the progress we have made to improve the Health and Wellbeing of our people;
- ensuring at least 90% of our people have received an annual appraisal;
- launching a new Yeovil District Hospital competency based Leadership Development Programme which all managers will attend.

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

The top five ranking scores compared to the national average for all acute foundation trusts in 2015/16, were as follows:

Top 5 Ranking Scores	2015/16	
	Trust	National Average
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	19%	26%
Percentage of staff experiencing discrimination at work in last 12 months	7%	10%
Support form immediate managers	3.85*	3.69*
Organisations and management interest in and action on health and wellbeing	3.73*	3.57*
Recognition and value of staff by managers and the organisation	3.56*	3.42*

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

The lowest five ranking scores compared to the national average for all acute foundation trusts in 2015/16, were as follows:

Lowest 5 Ranking Scores	2015/16	
	Trust	National Average
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	34%	31%
Percentage of staff appraised in last 12 months	82%	86%
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	16%	14%
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.66*	3.70*
Staff satisfaction with the quality of work and patient care they are able to deliver	3.89*	3.93*

Future Priorities and Targets

Yeovil District Hospital is an ambitious, vibrant and value-based organisation that needs exceptionally skilled, highly motivated and committed people who are driven by our core values. We want to be an organisation that is excellent to work for, where all staff are encouraged to give their best and where everyone is:

- Hired for their skills, passions and values.
- Involved and engaged.
- Inspired to do their best every day.
- Valued and supported to maximise their potential.

We are in the second year of our Organisation Development Plan, which is focussing on maximising the potential of everyone. We are working in partnership with Bath University to develop our leaders and future leaders, and we have developed our own in-house Leadership Development Programme.

We have developed this programme as we recognise our managers shape the way we do things and they provide the leadership atmosphere for our people to be more creative. We therefore strongly believe that as an organisation we need to nurture and develop our talent to be successful in the future.

Expenditure on Consultancy

£377k – 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.

Off-payroll Arrangements

Nothing to declare.

Exit Packages

	2016/17 Compulsory redundancies	2016/17 Other departures	2016/17 Total number	2015/16 Total number
< £10,000	1	15	16	2
£10,001 - £25,000	0	12	12	3
£25,001 - £50,000	1	8	9	4
£50,001 - £100,000	2	1	3	2
£100,001 - £150,000	1	1	2	1
Total Number	**5**	**37**	42	**12**
Total resource cost	**£304,000**	**£751,000**	**£1,055,000**	**£465,000**

Other (non-compulsory) departure payments

	2016/17 Number of Agreements	2016/17 Value of Agreements	2015/16 Number of Agreements	2015/16 Value of Agreements
Mutually agreed resignations (MARS) contractual costs	34	£725,000	6	£149,000
Contractual payments in lieu of notice	3	£26,000	2	£51,000
Total	**37**	**£751,000**	**8**	**£200,000**

Non-Contractual Departure Payments

There were no non-contractual departure payments made.

Board Members and/or senior officials with significant financial responsibility

	2016/17 Number of Engagements
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility".	15

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.

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

On 27 May 2016, NHS Improvement opened an investigation into the Trust's compliance with its licence in response to the Trust's deteriorating financial position against its 2015 Financial Recovery Plan (FRP).

The Trust received notification in April 2017 that the investigation had been concluded. The outcome was that, although NHS Improvement found evidence that it could technically hold the Trust in breach of its licence, it was their view that improvement would be more likely to be secured through a set of informal actions. They therefore decided not to take the formal step of placing the Trust into breach. The Trust has agreed a set of informal actions, which are currently being implemented. NHS Improvement will monitor progress against these with the Trust during 2017/18.

Yeovil District Hospital NHS Foundation Trust has been placed in segment 2. This segmentation information is the Trust's position as at May 2017. 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	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	4	4
	Liquidity	4	4
Financial efficiency	I&E margin	4	4
Financial controls	Distance from financial plan	2	1
	Agency spend	1	2
Overall scoring		**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 [name] 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 [name] NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- make judgements and estimates on a reasonable basis;

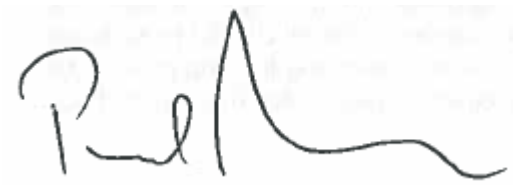
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;

- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and

- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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



Paul Mears, Chief Executive, 26 May 2017

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 2017 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Following a previous advisory piece of work undertaken by the internal auditors (BDO) in 2015/16 to assess whether risk management culture is embedded across the Trust, a number of improvements have been implemented in 2016/17. These include:

- Standardising how risks are recorded, reviewed and monitored by the strategic business units at monthly clinical governance meetings to ensure consistency across the organisation.

- Ensuring that staff are clear as to their responsibilities with regard to risk management and further communicating the details of the risk management strategy amongst staff. The Risk Manager provides guidance and training for all new senior members of staff on the risk management processes at Yeovil District Hospital and meets regularly with risk owners. In addition there is on-going training provided to management development programmes, principles of leadership training and nursing band 6 leadership programmes.

- The Risk Manager has worked with departments and service leads during 2016/17 and will continue to do so throughout 2017/18 to ensure all risks on the Trust's risk register, and identified risks managed locally within departments, are scored, actioned and reviewed appropriately.

During 2016/17, the internal auditors (BDO) undertook a further advisory piece of work (Maternity Risk Maturity) to assess whether a risk management culture is embedded throughout the maternity service. It identified a number of areas of good practice, including:

- The Department has a dedicated Risk Manager and Risk Management Strategy and Framework which provide the fundamentals and a framework for a sound system of risk management within a high risk area of the Trust.
- All staff joining the department are provided with an overview of risk management and their responsibilities within the risk management system during induction. Senior staff with a greater level of responsibility for risk management are provided with more in depth training sessions and complete risk management work books to evidence their understanding of risk management. Additionally the Trust Risk Manager is available where necessary to provide further guidance to those who require it.

- The Maternity risk register is a standing agenda item at meetings of the Maternity Risk Management Committee which facilitates regular discussion of specific risks and their associated plans for mitigation.

- The Maternity Risk Management Committee facilitates regular review of the Department's approach to risk management and this, along with the review of the Maternity Risk Management Strategy and Framework, ensures that the Department's approach to risk management can be adapted in the light of new risk information.

A number of recommendations were made against each of the areas of the risk maturity assessment, however the key findings are noted below:

- A more proactive approach to identifying risks complementing the reactive approach currently used by the department. This should involve aligning service risks to the department's objectives, alongside any actions required to mitigate these risks.

- The Maternity Risk Management Strategy and Framework will be reviewed and updated to take account of all recent changes which have occurred within the department. The Maternity Risk Management Strategy and Framework will be incorporated within the Trust's Risk Management Strategy to ensure consistency across services and to align processes.

- A review exercise should be undertaken of the Maternity risk register due to the number of entries on the register which have not had any progress updates provided for periods in excess of a year. All entries should be reviewed to identify whether they are still appropriate to be included within the register and updated where changes are found to be required. A more in-depth review of the risk register should be undertaken on a regular basis by the Maternity Risk Manager to complement the high level review undertaken at Maternity Risk Management Committee meetings. This is to ensure that the register is maintained at a standard which facilitates effective risk management within the department. A new Maternity Risk Manager has been appointed to undertake this exercise.

These recommendations have been reviewed and it is intended that these will be implemented in 2017/18.

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

The Director of Nursing and Clinical Governance is the designated executive director with Board level accountably for clinical quality, safety and risk management. The Medical Director and Director of Strategic Development support this role. Yeovil District Hospital has a designated Risk Manager within the clinical governance department.

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

Training

The Trust has an in-house programme of risk management training which is designed to equip staff with the necessary skills to enable them to manage risk effectively. The induction programme ensures that all new staff (clinical and non-clinical) are provided with details of internal risk management systems and processes which is augmented by local orientation. This includes the comprehensive induction of all junior doctors regarding key policies, standards and practice prior to commencement in clinical areas. Mandatory training reflects essential training needs and includes risk management processes such as fire, health and safety, manual handling, resuscitation, infection control, safeguarding and information governance. E-learning and workbooks support this programme. Skills and competencies are also assessed for medical device equipment and for blood transfusion to ensure safety in care.

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. Learning from incidents and claims is presented through the Patient Safety Steering Group whilst complaints are reviewed through the Patient Experience Committee which continually identifies opportunities for improvement. This learning is cascaded via monthly peer review and governance meetings and quarterly at Trust-wide multi-professional learning events.

An advisory piece of work was also undertaken (Integrated Learning) to assess whether a learning culture is embedded throughout the Trust. The final audit report identified a number of areas of good practice, including:

- The Trust has implemented the Safeguard complaints and incident management system to record and monitor complaints and incidents. This system has built in stages to assist department in completing their investigations and to record any required actions. The system also allows for reports to be generated supporting the tracking of open complaints and incidents.

- Monitoring reports for complaints and incidents are produced and reviewed by management and the Board of Directors. Complaints are reported and reviewed by the new Patient Experience Working Group, and incidents are reported and reviewed by the Patient Safety Steering Group. Complaints and incidents are also reported to the Strategic Business Unit Boards, the Governance Assurance Committee and a summary is reported to the Board of Directors on a monthly basis.

As part of the review, BDO also raised some opportunities for improvement, which have been implemented within 2016/17 including:

- The complaints team should ensure that all responses from the investigating manager are detailed SMART actions, with allocated responsible offers and clear implementation dates. As such, from May 2016 responses to complaints include detailed actions, with allocated responsible offers and clear implementation dates from the investigating manager. Managers have also been provided guidance on developing SMART actions accompanied by a template action plan for completion. The complaints team actively review all responses and request further detail where there is insufficient information.

- All staff responsible for the completion of actions on incident forms have been reminded of their responsibilities to either document SMART actions on Safeguard or record that consideration has been taken of the incident with no actions required; this includes signing off of incidents in order that these are closed. Spot checks on department led investigations are undertaken to ensure that actions have been identified and that these are SMART. Templates have been amended to provide the definition and reminder of SMART actions; the email templates are also undergoing amendment to include these changes. Additional training on incident management documentation and management of reviews will be scheduled for all managers through the year.

- A key performance indicator dashboard has been developed for the recording, reviewing and completion of complaints and incidents. Quarterly reports from the Trust-wide Integrated Learning Forum will be presented to Governance Assurance Committee to highlight organisational, team and individual learning and to highlight departments shown to be failing to investigate and close complaints and incidents in a timely manner. The Forum meets on a monthly basis with terms of reference reflecting all national guidance on learning from deaths, incidents and complaints is expected in April 2017.

- The remit of the Patient Experience Team and management of the complaints and PALS process will be integrated with the Clinical Governance Department in 2017. The Department will be renamed Quality Governance Department.

YDH 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 2014/15 and approved by the Audit Committee. The strategy will be reviewed in 2017/18. The Risk Management Strategy clearly sets out the acceptable level of risk within the Trust. A risk appetite statement has been agreed by the Board and is clearly communicated within the Risk Management Strategy. The risk appetite statement identifies what level of risk is acceptable at departmental level, and at which point this needs 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.

Directors of the Strategic Business Units, supported by Associate Medical Directors and Associate Directors of Nursing, have overall responsibility for managing risk in their areas. Risk registers are held for each of the Strategic Business Units and include all operational risks. Managers implement action plans and review the risks in line with the review dates set.

The Trust's Quality Improvement Strategy 2015-2018, which was reviewed and approved by the Board in 2015/16, is aimed at achieving excellence in clinical care. The Quality Report for 2016/17 sets out progress made in areas of patient safety, clinical outcomes and patient experience. Patient safety improvement work is monitored by the Patient Safety Steering Group which reviews and monitors data in the form of metrics. Information on quality and patient safety is received monthly by the Board and scrutinised in depth on a quarterly basis by the Governance Assurance Committee. Data quality is reviewed internally through Data Quality Steering Group, Information Governance Steering Group and through BDO as internal auditors who report to the Audit Committee.

Incident reporting forms part of the organisation's patient safety culture as does the importance of high level reporting, low level harm. Monitoring processes are in place to identify errors and risks and these are analysed for trends to prevent reoccurrence. Information is utilised from across the Trust from ward level to the Board. Where investigations are triggered, these are reviewed by the Clinical Governance team and the learning identified is reported back through clinical teams. Staff are encouraged to report incidents and support is provided by managers and through training. For example, junior doctors meet monthly to share their learning and experiences within a "no-blame" environment and undertake quality improvement projects which are presented to the Board at a seminar session.

Yeovil District Hospital has mechanisms to report serious incidents through the national reporting and learning system (NRLS) and to act on safety alerts, recommendations and guidelines made by all relevant central bodies such as NHS England, the Medical Healthcare Regulatory Authority (MHRA) and the National Institute for Health and Care Excellence (NICE).

The Quality Committee has an annual work plan which assesses key areas in line with national standards. In doing so, it identifies areas of compliance risk and co-ordinates action plans for mitigation. Exception reports from the Quality Committee are presented to the Governance Assurance Committee. The Director of Nursing and Clinical Governance presents on any CQC regulatory updates as part of the monthly executive report to the Board. The impact and requirements of CQC regulation are reflected within internal procedural documents. The quality, operational, financial and workforce performance report presented each month to the Board is categorised under the CQC standards. The Foundation Trust is fully compliant with the registration requirements of the CQC.

The Trust was subject to a CQC comprehensive inspection in March 2016 with the final report published in July 2016. The Trust was given an overall rating of Requires Improvement and a summary of the findings and actions taken are outlined in the Annual Quality Account.

A team of 40 inspectors assessed each of the 8 Core Services, Urgent and Emergency services, Medical care (including older people's care), Critical Care, Maternity and

Gynaecology, Surgery, Services for Children and Young People, End of life care and Outpatients and Diagnostic Imaging.

The inspection team spoke to staff, governors, patients and their carers, in addition to holding a public forum for feedback and also receiving feedback from our key partners. A number of focus groups were conducted, where specific staff groups had the opportunity to share any thoughts about the Trust and the services it provides, and interviews were held with the Chief Executive and Directors, Clinical Leads and Specialist Nursing and Medical Staff.

The inspection team were required to assess our Services and our Organisation against the 5 Key Domains:

- Safe
- Effective
- Caring
- Responsive
- Well-Led

The following ratings were achieved:

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

A comprehensive action plan was developed as result of the report and this has further informed the Trust's Quality Priorities. This action plan is subject to review and monitoring via the Governance Assurance Committee to ensure progress is evident. A further inspection, using the CQC modified inspection process, is anticipated in 2017/18.

The Care Quality Commission did not take enforcement action against YDH during 2016/17.

Nationally, the NHS is facing unprecedented levels of demand which have been reflected at Yeovil District Hospital. The Trust's primary district of South Somerset has a much higher proportion of residents aged over 65 (21.6%) than the rest of England (16.3%). This proportion is forecast to increase; estimates suggest that by 2030 there will have been a

43% increase in those aged over 55, compared to a static working population. Within this increase, the number of people aged over 85 is forecast to increase by 120%. Yeovil District Hospital also delivers services to a proportion of residents in North and West Dorset and parts of Mendip where the challenges are broadly similar.

The consequences of this are well known – ever increasing demand on health and social care coupled with a static working age population, and difficulties in recruiting sufficient staff to deal with the increasing demand and the complexity of patient conditions. This pressure is felt across the local health and social care economy; however with new models of care introduced at Yeovil District Hospital, the Trust has opposed the trend achieving national performance targets in the latter half of the year along with an improvement in its underlying deficit position and achievement of the control total set by NHS Improvement. Despite this, the Trust still faces a number of risks linked to this. Broadly, these are:

- Overcrowding in the emergency department in times of high demand;
- Increased demand resulting in escalation, cancellation of elective activity and risks to quality of care (including falls, pressure ulcers, medication errors and staff sickness);
- Challenges in maintaining safe staffing and safe services in times of escalation;
- Medical patients being nursed in non-medical environments, lack of medical support and lack of medical skills in workforce;
- The risk associated with the delivery of RTT standards, resulting from the cancellation of elective surgery; and
- Increased agency utilisation and expenditure.

Yeovil District Hospital has action plans in place to mitigate these risks, including an ongoing medical and nursing recruitment campaign, the creation of Symphony Complex Care Teams to provide a better way of supporting people living with three or more specific long-term conditions, the addition of reablement beds at Cooksons Court with the aim to getting patients home and the creation of new models of care including the delivery of systemised surgery through the formation of Daycase UK.

During 2016/17 the Trust also invested in a number of schemes that the Board considered vital in ensuring it maintained the quality of care provided to its patients. These included:

- Meeting safer staffing levels;
- Tag Care, a system of mitigating the risk of falls in a defined cohort of patients;
- Increasing junior medical cover and out of hours support services;
- Increasing midwifery staffing levels;
- Focusing on infection prevention and control; and
- Appointment of the Freedom to Speak Up Guardian and Guardian of Safe Working.

The Board has reviewed the areas of focus for quality improvement and developed a Quality Strategy that incorporates national recommendations, including safe staffing levels, and local priorities that reflect patients' needs. In addition, plans to develop and implement models to

provide enhanced seven day services, which will be a key enabler to preventing admissions at weekends and facilitating discharge, will improve the experience for patients.

In the long-term, and given the strategic nature of the challenges, Yeovil District Hospital has been progressing work with primary care and local partners on the development of radical new models of integrated care, which will deliver a sustainable, high quality health and social care system. Significant progress has been made; key highlights of which are:

- The establishment of Symphony Healthcare Services which has seen the integration of four GP practices to date, with another eight undergoing the due diligence process, two of whom are anticipated to be integrate within the coming months.

- Roll out of the new complex care and enhanced primary care models with over 3,600 patients having been touched by one of these models. Evidence suggests that this is starting to have a tangible impact on acute demand as evidenced by new Symphony operational dashboards.

- The establishment of Daycase UK, a joint venture between YDH and Ambulatory Surgery International (a major international provider of daycase surgery) to take forward our vision of developing a new model of 'systematised' surgery. Work has commenced to deliver efficiencies within the existing day surgery footprint.

- The development of a number of innovative partnerships with commercial organisations which are helping the Trust to realise its strategic ambitions.

- Commitment by Somerset CCG to issue an outcome based contract for South Somerset in 2017/18 which supports our journey to become an Accountable Care Organisation (ACO).

- Key enhancements to the Trust's physical infrastructure, including the development of a new multi-storey car park which opened in March 2017.

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

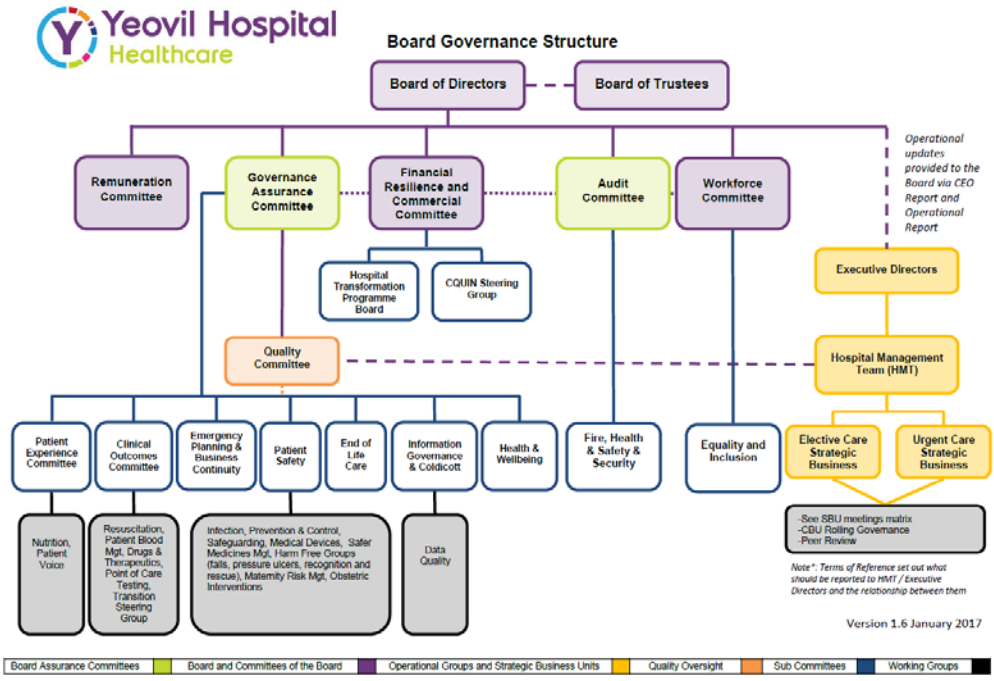
To ensure compliance with Condition 4 (Condition FT4) of the Trust's license with NHS Improvement, which relates to governance, NHS foundation trusts are subject to the recommendations of the NHS Foundation Trust Code of Governance (modelled on best practice UK governance principles) and the Well-Led Framework for Governance Reviews, which encourage Boards to conduct a formal evaluation of their own performance and that of its committees and directors. Accordingly, and as reported last year, during 2013/14, Ernst & Young LLP was commissioned to undertake a review of the performance and effectiveness of the Trust's Board and its committees. The recommendations were presented to the Board in March 2014. The overall findings were positive in acknowledging the Board and its committees were functioning well, although they identified some opportunities for improvement. An action plan containing the key recommendations was implemented in 2014/15 and into 2015/16.

The Trust has also implemented a number of amendments to previous processes, including the clarification of the roles, responsibilities and reporting structures of the Board alongside a review and revision of their terms of reference. A rolling agenda programme for the Board

and its committees has been created, accompanied by a development programme for the Board shaped through Board seminar sessions and Board monthly developmental away days.

Following previous reviews of the governance structure by the internal auditors, a revised governance structure was approved which streamlined and clarified the roles of the various committees and groups, various committees (such as Financial Resilience Committee and Commercial Committee) were merged to create overarching integrated governance committees which report directly to the Board. A Quality Committee was established where quality issues and the CQC standards of care are reviewed. In 2015/16, a Workforce Committee was established to meet on a monthly basis to advise the Board on the strategic, transformational workforce agenda and to review the monthly HR data sent to the Board. The committee focuses on agency staffing rates and expenditure, mandatory training, appraisal, occupational health, sickness management (including long term) and ESR data quality.

During 2016/17, the Board approved a revised governance structure in June 2016 and January 2017 following the creation of the Hospital Transformation Board (a group designed to help mitigate any risks to delivery of the Trust's strategic objectives as set out in the Board Assurance Framework) and the changes to the Patient Experience Strategy Group and the addition of the Transition Steering Group which reports directly to the Clinical Outcomes Committee. The Trust's current Board Governance Structure is show below:



Yeovil District Hospital has been selected to be one of the pilot sites for the joint NHS Improvement and Care Quality Commission's inspections of the well-led domain as well as the use of resources. This review will be undertaken in June 2017 and the results will be presented to the Board following this.

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 assurance committees and the Financial Resilience and Commercial Committee, Workforce Committee and Quality Committee.

The Board Assurance Framework is reviewed by the Strategy and Performance Working Group of the Council of Governors (as well as the Audit Committee and the Board). During 2016/17, Yeovil District Hospital held its annual general meeting along with the opportunity for members of the public to interact with staff from various departments and to provide feedback.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

As outlined earlier in the annual governance statement, ever increasing demand on health and social care, coupled with a static working age population and difficulties in recruiting sufficient substantive staff to deal with the increasing demand and the complexity of patient conditions has resulted in a challenged economic environment across the NHS. This has been compounded recently by a significant increase in the number of delayed transfers of care. While the Trust has a history of excellent performance and sound financial management, the existing, traditional models of care and incentives have continued to contribute to the Trust's deficit position in 2016/17. During late 2014 and early 2015, YDH undertook a deficit diagnostic with the support of Oliver Wyman Consultancy. The Financial Recovery Plan (FRP) that resulted was shared with NHSI as part of their investigation into the Trust's financial position; an investigation which resulted in no formal enforcement action and which recognised that YDH has the right plans and leadership in place to deliver long-term sustainability for the organisation through the creation of new models of integrated care, which has been recognised nationally with the award of Vanguard status, facilitating access to transformation funding to implement new models of care that will improve the service received by patients, whilst also delivering a sustainable financial position. In the short-term, and as a consequence of the planned deficit budget in 2017/18, the Trust will require short term financial support in the way of loans from the Department of Health.

To ensure ongoing monitoring and scrutiny, operational and strategic plans are reviewed by the Board and by the governor Strategy and Performance Working Group. Budget setting each year involves detailed analysis by qualified accountants within the finance team using current year actuals as a baseline. The team then works with departments and managers to review their proposed budgets, making amendments based on their input as required. The executive directors consider the draft budget in its entirety prior to non-executive and Board challenge, including thorough consideration by the Financial Resilience and Commercial

Committee. This robust process ensures that resources are planned on an economic, efficient and effective basis.

Overall performance is monitored via the quality, operational and financial performance overview at monthly meetings of the Board. Operational management and the co-ordination of services are delivered by the strategic business units which comprise executive directors, associate medical directors and associate directors of nursing. Performance was reviewed weekly by the Hospital Management Team in 2016 and bi-weekly in 2017. 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.

During 2016/17, following two years of planning and preparation, the Trust implemented phase one of TrakCare, its electronic patient record system as part of the SmartCare project. TrakCare provides for safer and better coordinated care through one united healthcare information system allowing a complete view of the patient's journey and is the first major step toward becoming paperless. The second phase due to go live in 2017/18 will allow the hospital to realise the real benefits of become a paperless hospital, with enhanced clinical functionality, electronic notes and electronic prescribing.

Information Governance

There were two Level 2 information governance breaches in 2016/17 that required external reporting in line with the information governance incident reporting tool. The Information Commissioner's Office (ICO) investigated the two separate incidents and decided in both cases no further action was necessary.

The first incident involved the inclusion of three appointment letters within one envelope therefore some patients received their own appointment letter along with two other letters. The ICO provided recommendations in relations to the incident; this included a review of the Trust's policies and procedures for handling data and a review of the Trust's approach to staff training. These recommendations have been actioned to ensure that this incident does not happen in the future.

The second incident concerned the carbon copying of patients via email within a cohort of patients. The ICO provided recommendations to be implemented following which the Trust has provided further training to members of staff group concerned. The decision has also been taken that this type of mass communication would be undertaken by the communications team to ensure that this incident does not occur again.

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

The Senior Information Risk Owner is the Chief Financial and Commercial Officer. The Information Governance toolkit remains an essential tool in monitoring progress against national standards and assessment of information security is undertaken annually as part of this process.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual. To provide assurance that the quality report presents a balanced view, the following arrangements are in place:

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

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

- Data quality is analysed monthly by the clinical governance and information teams.

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

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

- Compliance with NICE guidance is measured and monitored through the Clinical Business Units and the Clinical Outcomes 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 and Hospital Transformation Board.

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

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

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

Review of Effectiveness

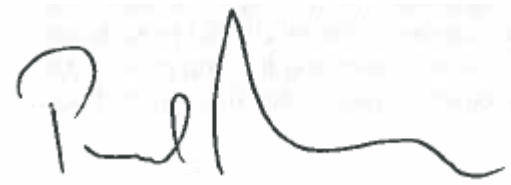
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical governance and the executive managers and clinical leads within Yeovil 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 Assurance Committee and Quality Committee; a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

The 2016/17 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.



Paul Mears, Chief Executive, 26 May 2017

Yeovil Hospital Healthcare

NHS

Yeovil District Hospital NHS Foundation Trust

Quality Account

2016/17

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Part One: Our Commitment to Quality

1.1 Statement from the Chief Executive

Welcome to Yeovil District Hospital ('YDH') NHS Foundation Trust's Annual Quality Account for 2016/17.

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 a busy year for Yeovil District Hospital; in 2016/17 44,145 people were admitted to our hospital, and 46,453 people attended our emergency department (A&E). More than 43,600 x-rays, MRIs, and other diagnostic tests and scans were carried out, and in our maternity unit, 1,509 babies were born.

For each one of these patients and interactions, a range of staff and services worked together, calling upon technology, equipment, expertise and experience to provide treatment and care which was both safe and effective. Only a relentless focus on quality enabled us to achieve this.

The Carter Report and NHS Five year Forward View make it clear that a sustainable and well-resourced workforce is an essential component of a high-performing, safe Trust and workforce development remains a Trust strategic priority. Ensuring appropriate staffing ratios within our wards is key to the quality of care and the implementation of the e-roster system across all wards is making it easier for us to ensure the right capacity and skill mix is in place at all times.

The continuing rollout of TrakCare – our Electronic Health Record – is also making the recording and sharing of clinical information quicker and easier.

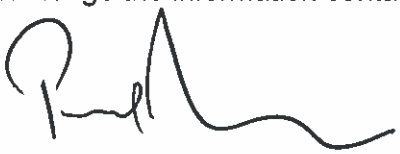
Recruitment of both registered and unregistered staff continued during 2016/17, with our unregistered nurse vacancies on the wards all filled by the end of the year. The first candidates from our recruitment drive for registered nurses in India are now arriving at the hospital and we will soon welcome colleagues from a further successful recruitment visit to the Philippines, with 190 registered nurses offered positions.

Innovation remains a core characteristic of our Trust and we have continued to develop partnerships and improvements to ensure the sustainability and performance of local services. Daycase UK, is a subsidiary of Yeovil District Hospital for the provision of day surgery and was established in early 2017 with an aim to provide swifter access to a range of surgical procedures, with improved outcomes for patients. And our Ambulatory Emergency Care unit is helping to speed up access to urgent care, caring for nearly 2,000 patients last year and helping them avoid admission to a hospital bed.

Meanwhile, Symphony, our programme of collaboration and improvement with primary care, continues to progress. Four practices have now integrated into Symphony Healthcare Services, providing care to more than 26,000 patients.

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 2016/17, 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.



Paul Mears, Chief Executive

26/5/17

1.2 Glossary of Terms

ALS	Advanced life support
BSI	Blood stream infection
CQUIN	Commissioning for Quality & Improvement
HCAI	HealthCare Acquired Infections
NICE	National Institute for Health and Care Excellence
PBL	Problem based learning
SMR	Standard Mortality Ratio
STP	Sustainable Transformation Plan
SI's	Serious Incident
RCA	Root Cause Analysis
AKI	Acute Kidney Injury

1.3 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 individuals
C effective Communication
A positive Attitude
R Respect for patients, carers and staff
E Environment conducive to care and recovery

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

1.4 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: We will be the UK leader in delivering new models of care

This is underpinned by a set of strategic priorities:

- Care of our population: Enabling our population to live healthier lives
- Developing our people: Enabling our staff to provide the care they aspire to
- Pioneer the future: Collaborating to create new models of care and commercial partnerships
- Put technology at the heart: Making ours the most technologically advanced hospital in the UK

Our strategic objectives are designed to provide focus on quality, sustainability and delivery across all aspects of the organisation.

These objectives align with our Quality Strategy and Sign Up to Safety Improvement Plan 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:

- SHMI;
- Mortality Rates;
- Serious incidents (including maternity);
- Number of incidents of avoidable harm;
- Number of healthcare associated infections;
- Performance against national CQUINs;
- Patient and staff feedback.

In addition, delivery of the Symphony programme to integrate and co-ordinate care and implementation of electronic health records continue to be key quality initiatives during 2017/18.

Key focus will be given to:

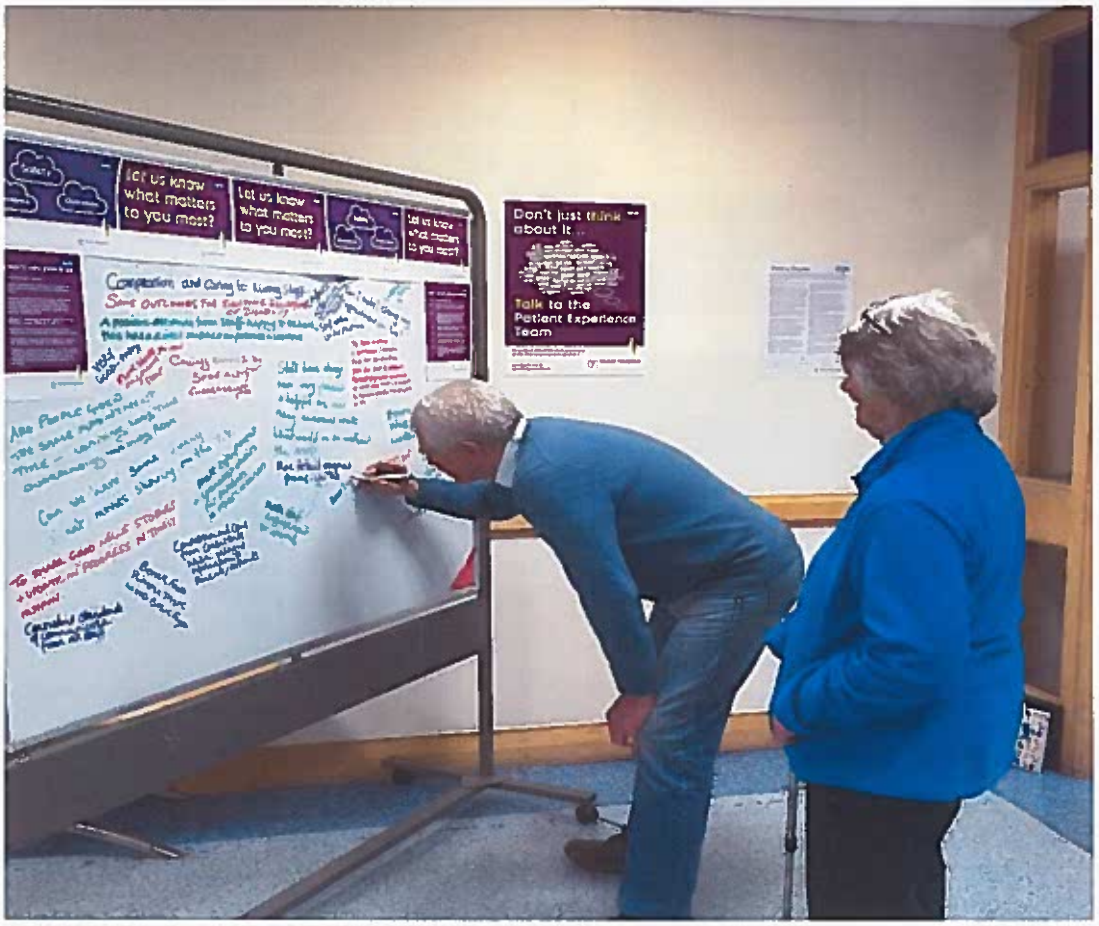
- Reducing variation in practice and making care safer;
- Using our skills in quality improvement to improve efficiency, timeliness and flow for outpatient, day case and inpatient services;
- Delivering services to patients in line with seven day standards;
- Investing in services to avoid unnecessary hospital admission and ensure timely and safe discharge;
- Promoting health and wellbeing to prevent illness;
- Better integrating care to meet patients' needs in the right place, at the right time, with the right staff;
- Use of technology to improve communication with patients, carers and families;
- Improving Safety in Maternity;
- Working collaboratively with partner agencies towards achieving STP ambitions with particular emphasis on delivery of seven day services, increasing opportunities to engage with patients and their carers and using of digital technologies to deliver integrated care planning.

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

2.1 Quality Improvement Priorities

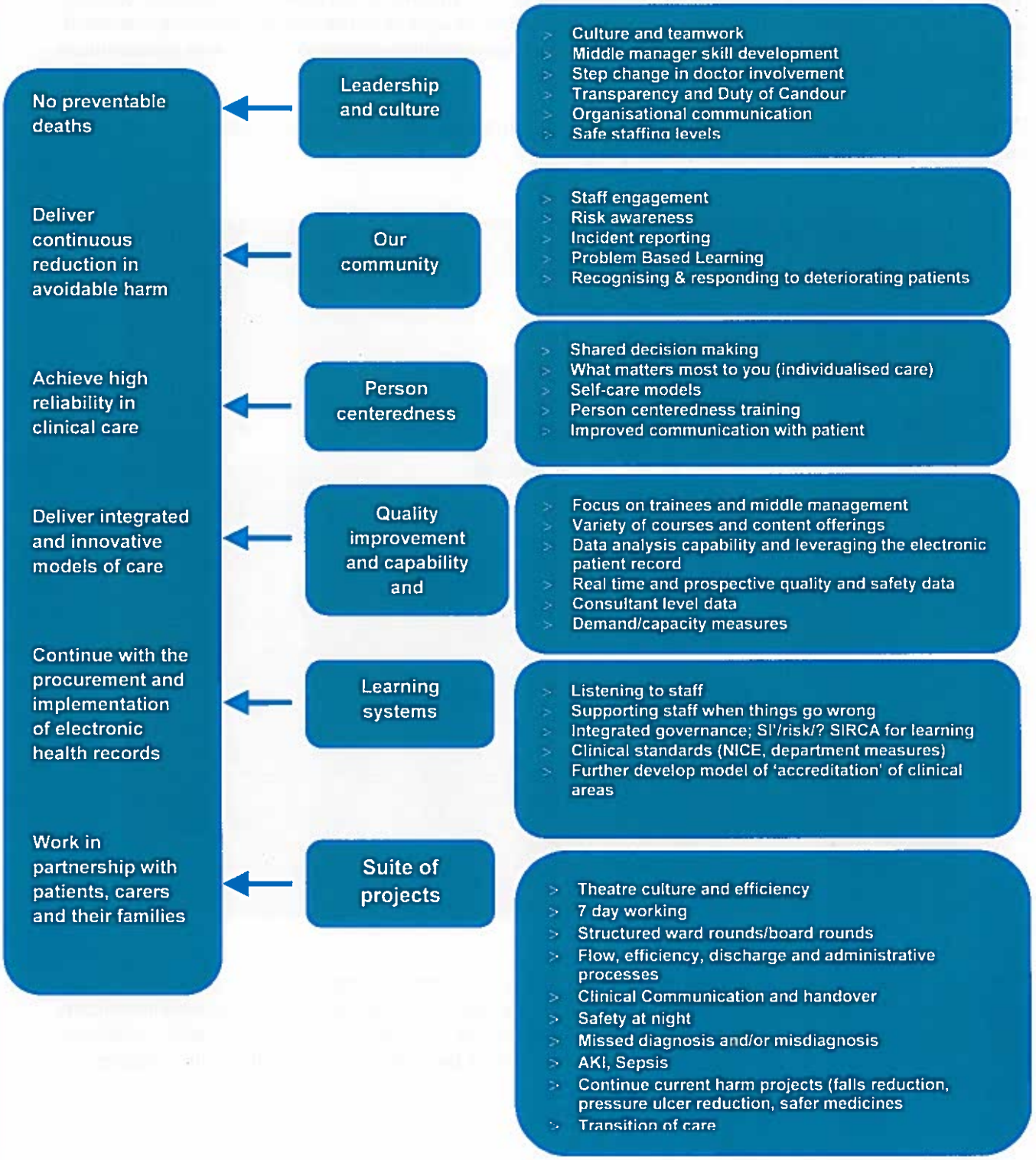
Yeovil District Hospital prides itself on keeping the quality of care at the forefront of service delivery and will ensure the safety, experience and effectiveness of care is of the highest possible standard. The Trust has focused its efforts on the delivery of key priorities during 2016/17 and will continue to drive forward improvements in these areas.

We held specific events to engage with staff, patients and their families including promoting the use of a graffiti wall to capture feedback on priorities.



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 at supporting the delivery of reliable and consistent change and members of staff from across the Trust have been trained to use these techniques.

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



Priorities and summary of performance to date

2016/17	Year-end Achievement
Priority 1	
No preventable deaths as measured by mortality ratios, Serious Incidents that resulted in deaths, mortality reviews, Copeland Risk Adjusted Barometer (CRAB) data	Our SHMI has remained within the expected range compared to other Trusts. The year-end position was reported as a SHMI of 1.0060 at December 2016. CRAB observed/expected ratio for deaths following surgery is 0.3 below the normal ratio of 1.0. Two deaths associated with an SI were considered as potentially avoidable. We reviewed all unexpected deaths to identify any opportunities for learning and have worked hard to implement processes for identifying deteriorating patients to ensure early intervention and treatment in conditions such as sepsis.
Priority 2	
Deliver continuous reduction in avoidable harm as measured by NHS Safety Thermometer, Never Events, Sign up to Safety Campaign Measures for common cause incidents (pressure ulcers, medication errors, falls)	The Trust reported 85 pressure ulcers (grade 2 and above) in 2016/17 compared to 75 in 2015/16. Despite not achieving an in-year reduction, this still constitutes a 62% reduction over the last 4 years compared to the 2012/13 outturn of 221. The final position for 2016/17 included all cases identified and did not differentiate between those that might be avoidable or unavoidable compared with previous measures. A total of 868 medication related incidents have been reported for 2016/17 compared to 820 for 2015/16. Of those reported, 24% involved an error that reached the patient. While the majority of these errors caused no harm to the patient, the number of incidents reported as "significant" (led to patient harm or required medical intervention) remained low at 3.4%. The Trust has continuously maintained its Safety Thermometer results above 95% for new harms.
Priority 3	
Achieve high reliability in clinical care as measured by compliance with care bundles for: Acute Kidney Injury (AKI), Sepsis, Pressure Ulcer Prevention, Falls prevention, use of structured ward and board rounds.	By March 2017 we had achieved a CQUIN performance of 87.26% of ED patients being screened for Sepsis and 62% having had antibiotics administered within an hour. Inpatient screening was 90.21% with 100% receiving antibiotics within the given timeframe. Compliance with care bundles for AKI, and pressure ulcer prevention require further improvement and will be a key area of focus with the move to electronic record. Significant improvements were achieved in the recognition and management of sepsis and daily

	boards rounds and formal consultant ward rounds were areas of particular focus and standardisation.
Priority 4	
Deliver a reduction in Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.diff) where lapses in care are identified. Target MRSA 0 C.diff 8.	There were 9 cases of Clostridium difficile infection attributed to the Trust (those which occurred more than 72 hours after admission) during 16/17 against a performance of 16 the previous year and a year-end target of 8. Only 2 were identified as lapses in hospital care against a target of 8. There were 0 cases of MRSA blood stream infection (BSI), although one case was attributed to a third party. As of 31 March 2017 it has been 718 days since the last BSI. A national drive to reduce resistant E.Coli (ESBL) infections will be of particular focus in 17/18.
Priority 5	
Reduce the number of patients falling in hospital who suffer moderate or significant harm by 10% compared with the outturn of 12 incidents for 2016/2017	In light of the failure to achieve the reduction in overall falls the previous year, the Trust set a target to have no more than 915 falls reported by year end 16/17 and this was achieved, with 57 fewer falls reported and a total of 829. The Trust had an aim to reduce falls resulting in harm by 10% this year however 20 patients fell and sustained moderate or significant injury compared to 12 in 2015/16. Preventing Fragility fractures will be an area of particular focus. During Quarter 4 we implemented TAG Care, a team approach to managing a number of patients at risk together and initial results demonstrate reductions. This approach will continue in 2017/18 and will continue to be reported against Priority 2
Priority 6	
Implement digital technologies to support delivery of timely and effective care including implementation and roll out of TrakCare as the Electronic Patient Record across the Trust.	Phase 1 of Trakcare implemented to replace previous Patient Administration System. Phase 2 roll out in progress and will continue throughout 2017/18.
Priority 7	
Patients, carers and members of the public will be treated as equal partners and have confidence that their feedback is being listened to and has improved delivery of services.	The introduction of 'iwantgreatcare' has enhanced our commitment to listening to patients and improved the way we gather patient feedback. The Trust chose to implement 'iwantgreatcare' to increase feedback support to inform service delivery. Actions from complaints are considered at a Trustwide learning forum to ensure actions are taken to improve patient experience and delivery of services.

Priorities for 2017/18

In reviewing our priorities and progress against 2016/17 plans, we have considered where further improvement is required and engaged with patients, families and staff to identify areas for particular focus. This has resulted in a number of changes to the quality priorities for 2017/18.

Priority 1	No preventable deaths as measured by mortality ratios, Serious Incidents that resulted in deaths and mortality reviews.
Priority 2	Deliver continuous reduction in avoidable harm as measured by NHS Safety Thermometer, Never Events, HCAI rates (including E.coli) Sign up to Safety Campaign Measures for common cause incidents (pressure ulcers, falls, medication errors).
Priority 3	Achieve high reliability in clinical care as measured by compliance with care bundles for: Acute Kidney Injury (AKI), Sepsis, Pressure Ulcer Prevention, Structured ward and board rounds and agreed staffing levels.
Priority 4 (New)	Deliver clinical services in line with National Seven Day Standards and measured by national audit participation.
Priority 5 (New)	Increase opportunities to engage with patients and their carers to understand what matters to them and plan with them accordingly.
Priority 6	Patients, carers, staff and members of the public will be treated as equal partners and have confidence that their feedback is being listened to and has improved delivery of services.
Priority 7	Implement digital technologies to support delivery of timely and effective care including implementation and roll out of TrakCare as the Electronic Patient Record across the Trust.

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

2.2 Statements of Assurance from the Board

Progress against the 2016/17 key priorities was monitored via a dashboard presented to the Board. The following section outlines the indicators, explaining the rationale for their inclusion and year on year progress against the measures. Further information on each of the indicators is included in Part 3 of this Account.

Priority 1: No preventable deaths as measured by HSMR, Serious Incidents that resulted in deaths, mortality reviews, Dr Foster mortality alerts

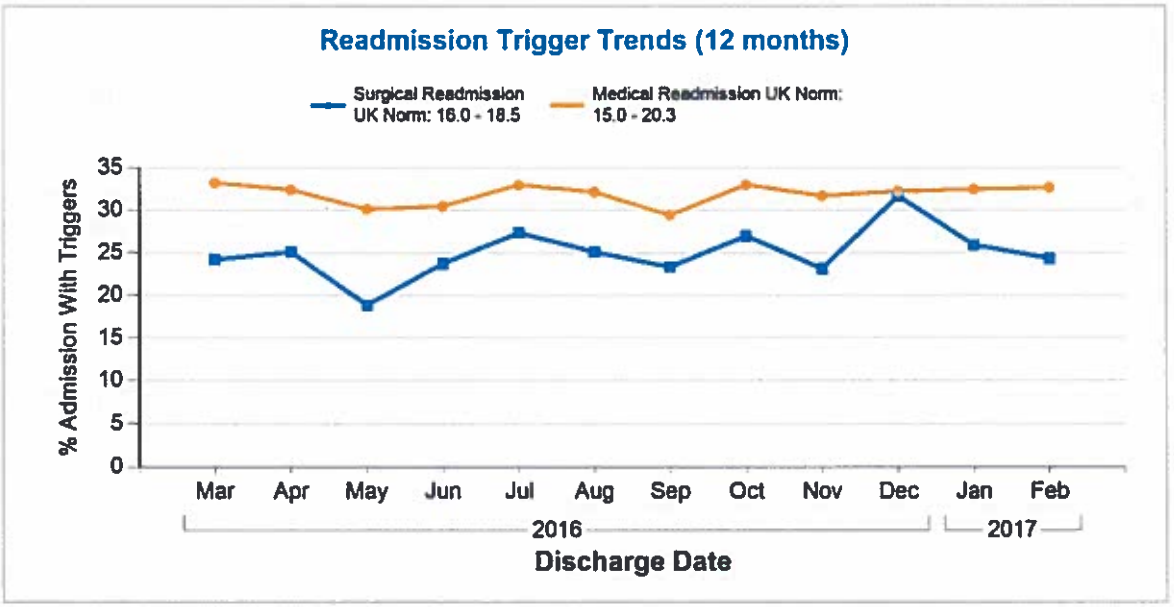
The Trust has changed its external mortality alert system and now uses the Copelands Risk Adjusted Barometer (CRAB) to provide outcomes data. This has taken the place of the Dr Foster mortality alerts and as a result the HSMR data is no longer available for the Trust. The Clinical Outcomes Committee continues to monitor outlier reports now produced by CRAB and is gaining experience in analysing consultant and specialty level data. The mortality data provided by CRAB also informs the regular mortality and morbidity process.

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

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

CRAB identifies the percentage of patients who were readmissions with or who developed one of these triggers. Patients are categorised into two groups, those who underwent a surgical procedure (surgical readmission) and those treated conservatively/medically (medical readmissions).

The following graph shows the Trust's overall readmission rate remains above the UK norm of 15.0 – 20.3. This is believed to be due to the inclusion of statistics from some of our day case attenders in areas such as the Acute Emergency Care Unit. The Trust will be changing the range of data submitted to ensure only inpatient readmissions are included and regular audit of patients will identify any opportunities to improve.



In the latter part of the year we introduced a more formal, trust wide approach to the way that we review deaths using a tool developed by the Royal College of Physicians. This enables the Trust to standardise the process of review and report learning. A clear focus is given to whether anything could have been done to prevent the death and ensuring that end of life care was good.

In Hospital deaths per month

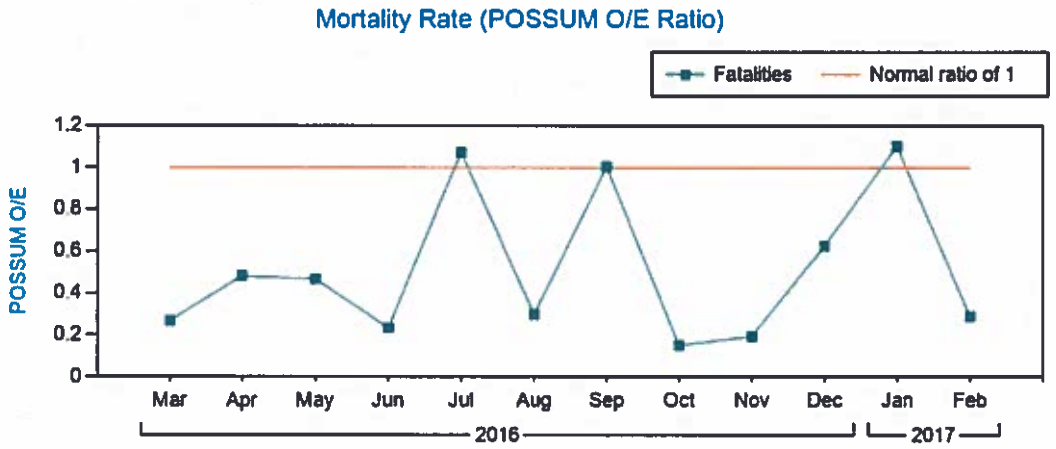
The number of deaths in hospital is captured through the **Summary Hospital-level Mortality Indicator (SHMI).** This reports mortality at trust level using a standard and transparent methodology which is published quarterly as a National Statistic by NHS Digital.

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 SHMI covering 12 months October 2015 to December 2016 is **1.0060** (with 1 being the expected norm).

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

Risk Adjusted Mortality



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

National Quality Board Guidance on Learning from Deaths (March, 2017) requires enhanced reporting of case note reviews during 2017/18. Focus will be given to standardising the review of deaths using a judgement review tool (Royal College of Physicians) and work is underway to ensure compliance with review and reporting requirements accordingly. Information will be reported and published quarterly highlighting key areas of learning.

Priority 2: Deliver continuous reduction in avoidable harm as measured by NHS Safety Thermometer, Never Events, Sign up to Safety Campaign Measures for common cause incidents (falls, pressure ulcers, medication errors)

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 VTE and if they have been given prophylaxis. The Trust has maintained its Safety Thermometer results above 90% throughout the reporting period with 95% of patients being recorded as harm free in April 2016 and 98% in March 2017.

As a sign of our commitment to reduce hospital acquired Pressure Ulcers, we will continue to monitor and report our position on hospital acquired pressure ulcers (Grade 2 and above). The Trust continues with the ambition of no hospital acquired pressure damage with investment in preventative actions being a key focus. At the end of the year, a total of 85 hospital acquired

pressure ulcers (Grade 2 and above) were reported against a Trust target of 75. Despite this reported increase, attribution of avoidability was stopped at the end of 2016/17 so this represents all cases reported, irrespective of whether there were any identified lapses in case. This year end position reflects an overall reduction of 62% compared to the baseline year.

Safer Medicines

The Trust aims to provide the best possible medicines optimisation and is working together (with patients and each other) to deliver safer and better outcomes from medicines. We collect meaningful data regarding missed doses across the Trust and report our findings to wards/departments and carry out ward based training in areas with high numbers of missed doses. We produce a Medication Safety Bulletin which focuses on missed doses with real incidents and clear actions for each healthcare group.

868 medication incidents were reported, with 24% of errors reaching 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 3.4% 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.

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

The Trust appointed a Simulation Trainer in early 2017 to work collaboratively with clinical staff to deliver Human Factors and Simulation based training, developing the workforce to further enable them to meet the needs of patients. The Simulation post strengthens current training approaches and provides particular focus on recognising deterioration and the need for using reliable systems and processes. The post is focused on Acute Kidney Injury (AKI), sepsis and respiratory failure in the first instance.

Acute Kidney Injury

We saw an increase in the percentage of key items relating to AKI being completed in patient discharge summaries from 49% in April 2016 to 70% in March 2017. AKI is a key priority for the Trust and work in this area is supported by the Recognition and Rescue Group which champions the early recognition and treatment of patients with community and hospital acquired AKI. The Recognition and Rescue group develops, implements, and monitors work streams relating to the recognition and rescue of patients by promoting a culture within Yeovil District Hospital NHS Foundation Trust that focuses on all aspects of Patient Safety Improvement. The group works hard to help staff improving recognition and management of the deteriorating patient. It also provides a forum to implement improvement methodologies for Recognition and Rescue and ensuring the safety and efficacy of patient care is secured.

Sepsis

In 2016/17 the work on Screening, Recognition and Treatment of Sepsis has expanded, from being focused in the Emergency Department, to all inpatients including Maternity and Paediatrics.

It has been a challenging winter and although some performance measures have fallen short of targets, the commitment of the staff and the improvements in comparison to 2 years ago are considerable.

We successfully piloted the Sepsis Tool created by the UK Sepsis Trust prior to the launch of the NICE Guidance last summer and have now implemented the guidance Trustwide.

We have produced a number of teaching videos that are now being used by many other Trusts. Yeovil District Hospital are actively working with other organisations across Somerset including the Clinical Commissioning Group, Taunton and Somerset NHS Foundation Trust, Somerset Partnership NHS Foundation Trust, South West Ambulance Service Foundation Trust, St Margaret's Hospice and GPs to ensure a swift and timely response when sepsis is recognised.

Ward/Board Rounds

This was an initiative to improve communication and Multi-Disciplinary Team working to support the improvement of quality and safety for patients. Nursing, pharmacy, therapy and medical staff meet together daily to discuss the management of all patients on a ward. This enables all staff to plan together, highlighting patient safety issues and prioritising the workload. Standardisation and roll out across the Trust is underway.

Safe Staffing

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

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

Right Care - Doing the right thing the first time in the right setting and ensuring 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 Carter Report and the NHS Five Year Forward View Planning Guidance 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 Trusts could learn what 'good' looks like from other Trusts and adopt their best practice. Dashboard data is being used to inform the focus on improvement.

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

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

The Safe Care Module, a functionality of e-roster which allows us to review patient acuity and dependency, is currently being implemented. This will be used together with Care Hours Per Patient Day (CHPPD) to further ensure safe staffing. The Trust consistently reports CHPPD. This will be triangulated with acuity scores to ensure safe staffing levels and is being implemented with roll out planned 17/18.

Particular attention has been paid to working with junior doctors to improve staffing levels and senior supervision and support out of hours. Increases in junior, middle grade and consultant posts have taken place throughout the year. Extensions to hours of consultant cover in the Emergency Department, 7 day phlebotomy and Assistant Practitioner support are in place and a commitment to increase hours of Critical Care Outreach cover in early 2017 has been made.

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

Priority 4: Deliver a reduction in MRSA and Clostridium difficile where lapses in care are identified. Target MRSA 0, C.diff 8.

The Trust achieved the zero tolerance required for MRSA blood stream infections in 2016/17. The Trust reported 1 MRSA BSI in November 2016. However this was attributed to a Third party and not attributed to lapses in care by the Trust. By the end of March 2017 the Trust had reached 739 days since it last reported a hospital acquired MRSA blood stream infection (BSI).

Nine cases of Clostridium difficile were identified (against a target of 8), however, only 2 were assessed as attributable due to lapses in care, namely antibiotic prescribing outside of Trust guidelines. Figures are submitted to the National Health Care Associated Infection (HCAI) data

capture system and are monitored by commissioners and Public Health England as national contract requirements. Key actions involve an improved focus on antibiotic prescribing, including audit and performance which is reviewed monthly by each Business Unit.

Priority 5: Reduce the number of patients falling in hospital who suffer moderate or significant harm by 10% compared with the outturn for 2016/2017

Whilst the overall numbers of falls was 829 compare with 951 the previous year, there was an increase in falls resulting in moderate or severe harm with 20 incidents in 2016/17 compared to 12 in 2015/16. The multi-disciplinary falls group focused on training, education and staff compliance with risks assessments however, an increase in the admission of frail, older patients during the winter months resulted in incidents of harm from falls often associated with delayed transfers of care and extended lengths of stay.

In response, a new approach, named TAG Care, was introduced by nursing staff on one ward. Focus is given to safe placement of patients in areas that are highly visible to ward staff, co-horting high risk patients together and maintaining a permanent staff presence at times of greatest risk. The approach includes a comprehensive assessment of all at-risk patients, accuracy of risk assessments and patient-centred care plans, use of visual aids to improve the communication of risk to all staff and staff wearing a physical tag to ensure responsibility is handed from member to member. Nurses, Physiotherapists, Occupational Therapists, Pharmacists and Doctors are all engaged in this approach. The initiative has been shortlisted for a National Patient Safety Award.

Priority 6: Implement digital technologies to support delivery of timely and effective care including implementation and roll out of TrakCare as the Electronic Patient Record across the Trust.

The Trust has achieved the first phase of implementation of a new electronic patient system, Trakcare, which went live in June 2016. This represents a significant change in record keeping and will impact on every department across the Trust. All Emergency Department attendances are now recorded using the new system and work is underway to implement electronic stock keeping, prescribing and inpatient record keeping across the remainder of the Trust in 2017.

Priority 7: Patients, carers and members of the public will be treated as equal partners and have confidence that their feedback is being listened to and has improved delivery of services

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

The number of patients who submitted a feedback survey has increased over the year from 1,194 in April 2016 to 1,666 in March 2017. A total of 16,564 surveys were completed over the course of the year with the year-end average of 92% patients likely to recommend the Trust to family and friends.

2.3 Participation in National Clinical Audit and Confidential Enquiries

During 2016/17 there were 51 national clinical audits and clinical outcome review programmes included in the Quality Accounts. Of these 32 were applicable to Yeovil District Hospital NHS Foundation Trust and the Trust participated in 31(97%). There was one national clinical audit that the Trust was eligible to participate in but did not - British Thoracic Society Paediatric Pneumonia Audit.

The national clinical audits and national confidential enquiries that Yeovil District Hospital NHS Foundation Trust participated in, and for which data collection was completed during the period April 2016 to March 2017 or audit reports were received, are listed below (46). The number of cases submitted to each audit or enquiry, as a percentage of the number of registered cases required by the terms of that audit or enquiry, are also listed.

National Clinical Audit Title	Cases submitted
National Institute for Cardiovascular Outcomes Research (NICOR) – Acute Myocardial Ischaemia National Audit Programme (MINAP)	Continuous audit of all eligible patients
National Institute for Cardiovascular Outcomes Research (NICOR) – National Heart Failure Audit	Continuous audit of all eligible patients
Royal College of Anaesthetists – National Emergency Laparotomy Audit	Continuous audit of all eligible patients
Royal College of Physicians Inflammatory Bowel Disease (IBD) Audit Programme – Clinical Audit of Biological Therapies	Continuous audit of all eligible patients
Royal College of Physicians – Sentinel Stroke National Audit Programme (SSNAP)	Continuous audit of all eligible patients
Royal College of Paediatrics and Child Health – National Paediatric Diabetes Audit (NPDA)	Continuous audit of all eligible patients
Health and Social Care Information Centre – National Diabetes Audit (NDA)	Continuous audit of all eligible patients
Health and Social Care Information Centre – National Pregnancy in Diabetes Audit (NPID)	Continuous audit of all eligible patients
National Perinatal Epidemiology Unit – Maternal, New Born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Continuous audit of all eligible patients
Royal College of Paediatrics and Child Health – National Neonatal Audit Programme (NNAP)	Continuous audit of all eligible patients
Intensive Care National Audit and Research Centre (ICNARC) – Case Mix Programme (CMP)	Continuous audit of all eligible patients
Intensive Care National Audit and Research Centre (ICNARC) – National Cardiac Arrest Audit (NCAA)	Continuous audit of all eligible patients
Trauma Audit and Research Network (TARN) – Severe Trauma Audit	Continuous audit of all eligible patients
Healthcare Quality Improvement Partnership (HQIP) – National Joint Registry (NJR)	Continuous audit of all eligible patients
Health and Social Care Information Centre – National Bowel Cancer Audit (NBOCAP)	Continuous audit of all eligible patients
Health and Social Care Information Centre – National Lung Cancer Audit (NLCA)	Continuous audit of all eligible patients
Royal College of Surgeons – National Audit of Oesophago-gastric Cancer	Continuous audit of all eligible patients
Royal College of Surgeons – National Audit of Prostate Cancer	Continuous audit of all eligible patients

Health and Social Care Information Centre – Patient Reported Outcome Measures (PROMS) for elective hernia surgery	Continuous audit of all eligible patients for part of year (data submission system change)
Health and Social Care Information Centre – Patient Reported Outcome Measures (PROMS) for elective hip replacements	Continuous audit of all eligible patients for part of year (data submission system change)
Health and Social Care Information Centre – Patient Reported Outcome Measures (PROMS) for elective knee replacements	Continuous audit of all eligible patients for part of year (data submission system change)
Learning Disability Mortality Review Programme (LeDeR Programme)	Data collection started in March 2017
NHS Blood and Transplant National Comparative Audit of Blood Transfusion Programme (NCABT) - 2017 Audit of the management of patients at risk of Transfusion Associated Circulatory Overload	Data collection started in March 2017
Royal College of Physicians – Falls and Fragility Fractures Audit Programme (FFFAP)	Data collection for next round to start in May 2017
Royal College of Physicians – National COPD Audit	Data collection for next round started in February 2017
BAPEN Nutritional Care Tool Audit	Data collection ongoing
British Thoracic Society Audit – Adult Asthma	100% minimum requirement
British Thoracic Society Audit – Smoking Cessation Audit	100% minimum requirement
NHS Digital – National Diabetes Inpatient Audit (NaDIA)	100% minimum requirement
UK Parkinson's – UK Parkinson's Audit 2015	100% minimum requirement
NHS Blood and Transplant National Comparative Audit of Blood Transfusion Programme - Red Cell and Platelet Transfusion in Adult Haematology Patients	100% minimum requirement
NHS Blood and Transplant National Comparative Audit of Blood Transfusion Programme (NCABT) - 2016 Audit of Patient Blood Management in Adults Undergoing Scheduled Surgery	100% minimum requirement
Royal College of Physicians – 2015 National End of Life Audit Dying in Hospital	100% minimum requirement
Royal College of Psychiatrists – National Audit of Dementia	100% minimum requirement
Cystic Fibrosis Trust – UK Cystic Fibrosis Registry	100% minimum requirement
The College of Emergency Medicine – Asthma Audit	100% minimum requirement

The College of Emergency Medicine – Severe Sepsis and Septic Shock Audit	100% minimum requirement
The College of Emergency Medicine – Consultant Sign-off Audit	100% minimum requirement
The College of Emergency Medicine – VTE risk in lower limb immobilisation in plaster cast	100% minimum requirement
The College of Emergency Medicine – Vital signs in children	100% minimum requirement
The College of Emergency Medicine – Procedural sedation in adults	100% minimum requirement
National 7 Day Working Audit	100% minimum requirement
Right Iliac Fossa Treatment Audit (RIFT)	100% minimum requirement
National Audit of Small Bowel Obstruction	100% minimum requirement
National Ophthalmology Audit	100% minimum requirement
The British Society for Rheumatology – National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis	60 cases submitted 26 complete (including returned PROM data) cases included (43%)

All published audit reports are reviewed by the clinical teams and the publication reported at the Clinical Outcomes Committee. Following review of the reports the key findings, recommendations and action plans are presented at relevant meetings and the Clinical Outcomes Committee.

Presentations included audit reports from the following audit programmes.

Royal College of Anaesthetists – National Emergency Laparotomy Audit

The aim of this audit is to examine the structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy. Trust performance is measured against the delivery of key processes of care for patients undergoing emergency laparotomy (24 hours a day, 7 days a week). The Trust's compliance is under 80% for 4 key processes and areas of service to be improved include documenting risk before surgery, pre-operative review and presence in theatre by consultant surgeon and anaesthetist and assessment by elderly medicine specialist in patients > 70 years.

This is an ongoing audit with an action plan that is being monitored by the Elective Care Business Unit. The Trust also received an Emergency Surgery Peer Review during the year and work is underway to improve overall compliance.

National Institute for Cardiovascular Outcomes Research (NICOR) – National Heart Failure Audit

The aim of this audit is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease. Trust performance was measured against key performance indicators. The Trust's compliance is under 80% for 2 key processes and areas of service to be improved include treating patients on a dedicated cardiology ward and prescribing all three disease modifying drugs.

Royal College of Physicians – End of Life Audit Dying in Hospital

The aim of the audit was to review the 5 priorities of care set out by the Leadership Alliance for the Care of Dying People Report ('One Chance To Get It Right'). Trust performance was measured against the 5 priorities of care with 3 priorities reporting under 80% compliance. Areas of service to be improved include communication and documentation of the recognition that a patient may die as early as possible and documentation that the needs of the person(s) important to the patient are asked about. Increased use of the Last Days of Life Communication Tool, together with targeted training and increased use of Treatment Escalation Plans and Allow a Natural Death forms, is aimed at improving compliance.

Royal College of Physicians - Inflammatory Bowel Disease Audit Programme – Clinical Audit of Biological Therapies

The aim of the audit is to measure the efficacy, safety and appropriate use of biological therapies in patients with inflammatory bowel disease in the UK. The audit also aims to collect patient's views on their quality of life at intervals during their treatment.
Recommendations were made surrounding screening prior to treatment, infliximab biosimilars, minimum steroid use, documented follow up at 3 months and 1 year and auditing. The Trust's compliance is under 80% for adequate pre-treatment screening and documented follow-up at 3 months. Patient data is now submitted to the IBD Registry for national analysis.

UK Parkinson's Audit

The aim of the audit was to review the care received by patients with Parkinson's. The findings of the audit are to be used by participating services to shape their quality improvement plans and at a national level to prioritise the activities of Parkinson's UK and the UK Parkinson's Excellence Network. Two areas for improvement were identified in the Trust – increase patient awareness of bone health and ensure all patients are reviewed by the osteoporosis team and ensure all patients are signposted to Parkinson's UK and Parkinson's local advisor.

National Confidential Enquiries (NCEPOD)

During 2016/17 the Trust was 100% compliant with participation in eligible studies and entered data into the following 6 NCEPOD studies:

Study Name	Cases Included	Progress	Actions
Acute Pancreatitis Study	5	Report published 7 July 2016	Self-assessment checklist completed
Care of Patients with Mental Health Problems in Acute General Hospitals Study	1	Report published 26 January 2017	Self-assessment checklist completed
Young People and Young Adults Mental Health	5	Data collection completed	Awaiting publication of report
Non-invasive Ventilation Study	3	Data collection completed	Awaiting publication of report
Chronic Neurodisability Study – Cerebral Palsy	4	Data collection completed	Awaiting publication of report
Cancer in Children, Teenagers and Young People Study	Awaiting questionnaires for clinicians to complete	Data collection period	Awaiting questionnaires for clinicians to complete

2.4 NICE Quality Standards

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

148 NICE Quality Standards have been issued in total and 28 have been issued in the last year. Of the 148 Quality Standards 120 are applicable to the Trust.

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

Guidance Type	Publication	Applicable	Compliant	Partially Compliant	Non - Compliant	Under Review
Quality Standards	Total No.	120	59	45	0	16
	In last year	21	5	5	0	11

Partially Compliant Quality Standards include:

NICE Quality Standard 121 Antimicrobial Stewardship

This Standard is based on NICE Guideline 15 that was published in August 2015. The Standard was reviewed in April 2016 and our compliance was partial - Communication. The system of peer review and clinical governance meetings will be used to review compliance with antimicrobial stewardship and influence good prescribing habits. An action plan is in place with full compliance anticipated early in 2017/18.

NICE Quality Standard 125 Diabetes in Children and Young People

This Standard is based on NICE Guideline 18 that was published in March 2016. The Standard was reviewed in July 2016 and our compliance was partial - Access issues to psychological support; 24hr continuous glucose monitoring and blood ketone monitoring. An action plan is in place to work with Somerset Partnership Trust to strengthen arrangements for psychological support with the Diabetes Steering Group developing plans for improved monitoring.

NICE Quality Standard 130 Skin Cancer

This Standard is based on NICE Guideline 34 that was published in February 2016. The Standard was reviewed in September 2016 and our compliance was partial - Congruent with guidance; do not currently check Vit D status in all patients with melanoma. This may change depending on further clinical evidence regarding monitoring and supplementation.

NICE Quality Standard 138 Blood Transfusion

This Standard is based on NG24 that was published in December 2016. Issues to be addressed are optimisation of Hb pre and post op (co-ordination between primary and secondary care and providing an anaemia / patient blood management (PBM) service), agree the protocol for the use of tranexamic acid and PBM training / awareness for prescribers of blood components. An action plan is in place and will be monitored by the Patient Blood Management Committee.

2.5 Participation in Local Clinical Audits

A total of 139 local clinical audits and surveys were performed during 2016/17 and of these 74 (53%) were completed by 31/03/2017. 40 (29%) are at the data collection stage. 13 (9%) are at the analysis stage. 12 (9%) of audits were abandoned for various reasons including member of staff leaving Trust, re-design of audit and covered by national audit data collection.

The following audit summaries provide examples of changes in practice recommended to improve the quality of healthcare provided:

Radiology – Contrast Reaction Audit

The aim of the audit was to review the management of patients following a reaction to contrast against local and national guidelines.

Key Findings:

- Incomplete information documented when a patient has had a reaction to contrast;
- 'Alert' status not altered when a patient has had a reaction to contrast.

Recommendations:

- Enter full details of the reaction to contrast on the Radiology Carestream RIS system (complete all fields in 'Contrast' section, 'Other Contrast' section and 'Drugs Administered' section);
- Review drugs included in the drop down list for 'Drugs Administered' (to address antihistamine omission);
- Alter 'ALERT' status when a patient has had a reaction to contrast;
- Any care given by radiology staff/nurses should also be recorded (including observations recorded, aftercare instructions given and length of time before discharge);
- Maintain a log within the Radiology Department of all contrast reactions for audit purposes.

Sampling method and monthly review of compliance.

Radiology Intervention - Patient Safety Checklist

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

Key Findings:

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

Recommendations:

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

To be measured using a monthly sampling strategy and reviewed as part of the Trust work on National Safety Standards for Invasive Procedures (NatSSIPs).

Audit of Methotrexate Prescribing for Dermatological Conditions

The aim of the audit was to assess prescribing and monitoring of methotrexate for skin disease in dermatology at YDH and to identify any recommendations that may improve the safety and care of those receiving methotrexate including avoidance of unnecessary investigations.

Recommendations:

- Consider screening for Hepatitis B, C and HIV;
- Consider checking VZV serology if no history of varicella;
- Consider a baseline CXR if history of lung disease or symptoms (but do not necessarily screen all patients);
- Monitoring of P3NP in those with psoriasis needs improvement (check 4 times a year);
- May require written documentation of P3NP result in notes, or ensuring paper result is accurately filed (? discuss with laboratory to enter on OrderComms as TST);
- Monitor bloods appropriately as guidance (or if dose change / renal impairment / elderly / abnormal result more frequently) but not excessively.

Audit of pathway for UKR/TKR

The aim of the audit was to review the current analgesic pathway for patients who have had knee operations (UKR/TKR) comparing the Standard Pathway Group with the Tapentadol Pathway Group.

Key Findings:

- Reduced length of hospital stay for those patients on the Tapentadol Pathway.

Recommendations:

- Audit results support the ongoing use of Tapentadol;
- Explore the option of converting to modified release prep to reduce the work load of the nursing staff.

Audit results to be presented to the Drugs and Therapeutic Committee.

Intrauterine insemination treatment - patient information

The aim of the audit was to review the provision of patient information. An HFEA licence has to be obtained to carry out IUI treatment. Under the conditions of this licence adequate patient information must be provided.

Recommendations:

- To either check the quality of all photocopied patient information or have leaflets printed;
- To review the availability of patient information in different languages;
- To ensure all details of information provided is documented in the medical notes.

Actions:

- Liaise with the communication officer to get all our patient information leaflets translated into different languages appropriate to our patients;
- Liaise with communication officer to produce a visual information leaflet on how to use HCG;

- Re design the IUI Planning Appointment sheet to incorporate detailed documentation of information given to the patient.

Intrauterine insemination treatment - patient consent

The aim of the audit was to review the procedure to obtain patient consent. An HFEA licence has to be obtained to carry out IUI treatment. Under the conditions of this licence detailed patient consent must be sought.

Recommendations:

- To ensure all details of the consultation are fully documented including all information provided to the person giving consent.

Actions:

- Re-design the IUI Planning Appointment Sheet to incorporate more detailed documentation of information given to the patient.

Prevention of hypoglycaemia in At Risk Neonates

The aim of the audit was to review the Trust guidelines on management of babies at risk of hypoglycaemia.

Recommendations:

- Change pathway 1 of guidelines in at risk babies to include offering 10-15 mls/kg top up EBM/Formula immediately irrespective of mode of feeding.

To be re-audited in 2-3 months

Sacral Ultrasound use in Neonates Audit

The aim of the audit was to assess referral criteria for sacral ultrasound in new born babies and develop guidelines for Yeovil District Hospital regarding sacral ultrasound.

Recommendations:

- Design a referral form that includes the indications for sacral USS referral (sacral dimple without visible base, peripheral stigmata of spinal dysraphism such as tuft of hair, skin tags, haemangioma);
- Detailed examination to identify the base of the dimple.

2.6 Research and Development

The Trust has a commitment to using research as a driver for improving the quality of care and patient experience. The number of patients recruited by Yeovil District Hospital NHS Foundation Trust in 2016/17 was 790 which was a reduction from 825 the year before. This is due to the movement towards more targeted therapies and personalised medicine in oncology which has changed the design of research studies which has led to decreased recruitment targets for these individual studies.

There are presently 88 studies open and recruiting, inclusive of randomised clinical trials, observational studies, and one sponsored and led by the Trust. Participation in clinical research demonstrates Yeovil District Hospital NHS Foundation Trust's commitment to improving the quality of care we offer and to make our contribution to wider health care improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads

to the best possible patient outcomes. We take part in the South West Peninsular Clinical Research Network Patient Experience questionnaire every year and this year it was run over a 3 month period and we asked every patient who was followed up for a non-oncology research study to take part. This will enable us to look at areas that patients are traditionally not coming into hospital for regular study visits as in oncology.

34 new clinical research studies were opened across directorates during 2016/17 which was an increase from 29 in the previous year. Research active services include Oncology, Haematology, Cardiology, Diabetes, Stroke Services, General Surgery, Orthopaedics, Elderly Care, Endocrinology, Gastroenterology, Dermatology, Paediatrics, Emergency Care, Critical Care, Radiology, Pathology and Neurology. We have welcomed some new Principal Investigators (PI) and research teams into research such as the hand therapy team and will be assisting them to run their first studies. We also have several non-medical PI's who are clinical nurse specialists and research nurses. By taking part in these studies it increases new knowledge for our clinical staff and facilitates the sharing of good practice between national and international trial sites as regular teleconferences, webinars and newsletters are sent from the main trial teams.

By running clinical research studies we are bringing in new techniques, treatment options and opportunities for patients within the hospital. There are several examples of this such as the MENOS four study. This is run by two of our breast care clinical nurse specialists and they have received training in Cognitive Behavioural Therapy by the study team to see if this reduces the impact of hot flushes in woman suffering from breast cancer. We are also taking part in a study called UKGRIS- Effectiveness of the GRACE risk score on the management and outcome of patients hospitalised with non-ST elevation acute coronary syndrome. This has the potential to change clinical practice within the hospital and is led by a consultant cardiologist but requires all junior medical staff to be involved.

The Nuffield Trust is undertaking a National Institute of Health Research (NIHR) - funded study about models of Medical Generalism in Smaller Hospitals and chose us a site to participate and they attended for a 2 day visit in March. This is a 2.5 year study aiming to identify the models of medical generalism in smaller hospitals and explore their strengths and weaknesses from patient, professional and service perspectives. We have also increased our commercial activity this year and have opened eight studies and six have recruited to time and target and two are still recruiting. These have been opened in cardiology, gastroenterology, oncology (lung and breast), dermatology and stroke. This has led to us being the top recruiting small Acute Trust in the NIHR league tables this year.

We have been instrumental in setting up the 100,000 genomes project rare diseases arm within the hospital and now have rolled this out to all clinicians to take forward with a local consultant lead and we will have the cancer arm opened within the first quarter of the 2017/18. The project will sequence 100,000 genomes of patients with cancer or families with rare disease. The aims of the project are to improve diagnosis of patients with rare disease and increase understanding of tumour variants that predict therapeutic response to targeted cancer drugs. It also aims to accelerate the uptake of genomic medicine in the NHS and enhance UK industry and investment in genomics.

We ran a successful event for professionals and the public in the form of a celebration of the research unit being 21 years old. Each research speciality put on a display and we invited national speakers and a patient representative to speak about their research experiences. This was a successful event with over 100 people attending and raised the profile of research within the hospital and externally as it was communicated by the media and promoted on social media.

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

Mr Nader Francis was successful in obtaining a grant of 50,000 Euros from the European Association of Endoscopic Surgeons (EAES) in April 2016 and this has enabled us to open a multicentre study in collaboration with a commercial partner looking at the role of 3D imaging in laparoscopic rectal surgery. The protocol was developed with input from patients in a local support group and a patient sits on the trial management group meetings to ensure patient involvement at every stage of the study. This study is recruiting ahead of schedule in 4 sites and has been adopted onto the NIHR portfolio.

The research department supports a surgical research fellow who worked with Mr Francis to submit seven collaborative grant applications with a successful first round application for a £250,000 NIHR Research for Patient Benefit (RfPB) grant. They have had numerous abstracts and given many presentations at national and international meetings. We await the outcome of round two but if successful the Trust will sponsor a large multicentre study looking at urinary biomarkers in colorectal cancer. Additionally, in the last year, the team have published seven articles in international journals. We hosted a Nuffield research placement for a student and their project of auditing delegation logs has been accepted as a poster presentation at the Research and Development Forum's annual conference later in the year. This project aims to assist the researchers of the future and gave the student a varied experience of clinical research within a district general hospital.

We have formed a collaboration with Musgrove Park Hospital and Somerset Partnership to enable research to be delivered easily throughout Somerset but also with the view of increasing dementia research within the region. We also host an NIHR research nurse post here in the department that enables a member of staff to work with the South West Peninsular Research Network and go out to primary care and assist GP practices with recruiting research patients.

We have partnered with Bournemouth University and have successfully won a bid to host a nursing PhD post. In collaboration with the nurse consultant for dementia this post will support a nurse to work clinically for two days and then on their PhD for the remaining three days. This innovative post will be a study exploring the impact on older people's health and wellbeing from compassionate communication during their admission and in-hospital stay.

In summary we are currently the highest performing small acute Trust for commercial research recruitment in the country. We have recruited across a broad portfolio of specialities and are giving patients many opportunities to participate in new treatments and staff to be part of a high performing research active organisation.

2.7 Commissioning for Quality and Innovation

A proportion of Yeovil District Hospital NHS Foundation Trust income in 2016/17 was conditional upon achieving quality improvement and innovation goals 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. 2016/17 saw the CQUIN frame work also support the transition to Somerset Together commissioning model in driving patient centred care and transformational change in the way services are delivered.

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 2016/17 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 ED and Inpatient settings as well as ensuring that antibiotic reviews were undertaken within 3 days;

- Empowering people with long term conditions to have the knowledge, skills and confidence to manage their own health by implementing a number of areas which focused on user experience, care planning and activation measures;

- A continued move towards the promotion of prevention and early intervention for those patients who might be classified as frail in order to improve patient outcomes.

- Sharing and standardisation of workforce training to ensure a well trained workforce is in place to deliver the new models of care for now and future years.

- Development and commitment to an interoperable platform to achieve an integrated digital health and care record.

2.8 Trust Income against Commissioning for Quality and Innovation Payment Framework

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

The income Yeovil District Hospital Foundation Trust receives is conditional on achieving national and locally agreed goals, this equated to £2,100,000 in 2014/15, £2,060,000 in 2015/16 and the following for 2016/17:

- Somerset; £1,857,342;
- NHS E – Specialised Services; £76,000;

- Public Health; £20,864;
- Military Health; £7,902;
- Dorset; £346,487;
- Total = £2,308,595.

The CQUIN achievement for 2016/17 was achieved in full with the exception of £11,000 against flu vaccination targets. The Trust achieved 60% compliance against a target of 75%.

The Trust CQUIN programme for 2017/18 will focus on supporting the transition to Somerset Together commissioning models and delivery of the Sustainable Transformation Plan and includes relevant National CQUINs.

2.9 Review of Our Services

During 2016/17 Yeovil District Hospital NHS Foundation Trust provided 45 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.

The income generated by direct provision of NHS services was approximately 81.7% of total income.

2.10 Registration and Compliance

The Trust was subject to a CQC Comprehensive Inspection in March 2016 with the final report published in July 2016. The Trust was given an overall rating of Requires Improvement and a summary of the findings and actions taken are outlined in the Annual Quality Account (Quality Report).

A team of 40 inspectors assessed each of the 8 Core Services, Urgent and Emergency services, Medical care (including older people's care), Critical Care, Maternity and Gynaecology, Surgery, Services for Children and Young People, End of life care and Outpatients and Diagnostic Imaging. The inspection team spoke to staff, governors, patients and their carers, in addition to holding a public forum for feedback and also receiving feedback from our key partners. A number of focus groups were conducted, where specific staff groups had the opportunity to share any thoughts about the Trust and the services it provides, and interviews were held with the Chief Executive and Directors, Clinical Leads and Specialist Nursing and Medical Staff.

The inspection team were required to assess our Services and our Organisation against the 5 Key Domains:

- Safe;
- Effective;
- Caring;
- Responsive;
- Well-Led.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Each services ratings are described in the following table:

CQC Service Ratings

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

Areas for improvement included:

- Improving staffing levels in the Emergency Department;
- Requesting an invited review by the Royal College of Paediatrics and Child Health to review the Model of Care for Children and Young People;
- Improving aspects of infection control across the Trust;
- Increasing compliance with staff appraisals;
- Strengthening arrangements for End of Life Care in line with National Standards;
- Improving compliance with risk assessment and care planning for inpatients;
- Increasing 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.

A comprehensive action plan was developed as result of the report and this has further informed our Quality Priorities. This action plan is subject to review and monitoring via the Governance Assurance Committee to ensure progress is evident. A further inspection, using the CQC modified inspection process, is anticipated in 2017.

The Care Quality Commission has not taken enforcement action against Yeovil District Hospital NHS Foundation Trust during 2016/17.

2.11 National and Contractual Quality Standards

Domain	Indicator	Source	Latest Date Range	This Years Value	Last Years Value	Best Performance (National)	Worst Performance (National)	National Average	National Target
Organisational Health	Overall patient Experience of Hospital Care	NHS Digital	Jul15-Jul16	76.5	76.9	88.0	70.6	77.3	-
	Staff Sickness	Trust	Apr16-Mar17	3%	3%	-	-	-	-
	Staff Turnover	Trust	Apr16-Mar17	21%	16%	-	-	-	-
	NHS Staff Survey Response rate	Trust	Apr16-Mar17	64%	61%	77%	31%	44%	-
Effective	Palliative Care Coding	NHS Digital	Jul15-Jun16	29%	37%	55%	1%	26%	-
	SHMI	NHS Digital	Jul15-Jun16	101	104	-	-	-	100
	SHMI weekend	NHS Digital	Jan16-Dec16	103.9	-	-	-	-	100
	PROMS: Inguinal Hernia - EQ VAS	NHS Digital	Apr15-Mar16	33%	35%	63%	0%	38%	-
	PROMS: Inguinal Hernia - EQ-5D Index	NHS Digital	Apr15-Mar16	49%	52%	100%	19%	52%	-
	PROMS: Hip Replacement - EQ VAS	NHS Digital	Apr15-Mar16	71%	72%	81%	33%	66%	-
	PROMS: Hip Replacement - EQ 5D Index	NHS Digital	Apr15-Mar16	88%	95%	100%	76%	89%	-
	PROMS: Hip Replacement - Oxford Hip Score	NHS Digital	Apr15-Mar16	97%	99%	100%	87%	97%	-

Domain	Indicator	Source	Latest Date Range	This Years Value	Last Years Value	Best Performance (National)	Worst Performance (National)	National Average	National Target
	PROMS: Knee Replacement - EQ VAS	NHS Digital	Apr15-Mar16	67%	72%	100%	42%	56%	-
	PROMS: Knee Replacement - EQ 5D Index	NHS Digital	Apr15-Mar16	87%	82%	100%	66%	81%	-
	PROMS: Knee Replacement - Oxford Knee Score	NHS Digital	Apr15-Mar16	98%	94%	100%	80%	94%	-
	Readmissions in 28days: 0-15yrs	NHS Digital	Apr15-Mar16	2.91%	2.41%	-	-	-	-
	Readmissions in 28days: 16yrs+	NHS Digital	Apr15-Mar16	7.41%	6.56%	-	-	-	-
Caring	MSA Breaches	NHS Digital	Apr16-Mar17	2	4.0	-	-	-	-
	Complaints rate	Trust	Apr16-Mar17	12.6	12.0	-	-	-	-
	Staff - Friends and Family Test	NHS Digital	2016	66.1	68.0	-	-	-	-
	Maternity - Friends and Family Test	NHS Digital	Apr16-Mar17	87.3%	93.5%	-	-	-	-
	Inpatients and Daycases - Friends and Family Test	NHS Digital	Apr16-Mar17	90.6%	90.8%	-	-	-	-
	Emergency Dept- Friends and Family Test	NHS Digital	Apr16-Mar17	90.4%	92.3%	-	-	-	-
Safe	VTE Risk Assessment	NHS Digital	Apr15-Mar16	96%	97%	100%	80%	96%	95%
	Safety alerts	NHS Digital	Apr16-Mar17	0	0	0	4	0.2	-
	Never Events	NHS Digital	Apr16-Mar17	2	1	-	-	-	-
	Emergency C -Section Rates	Trust	Apr16-Mar17	15.5%	13.0%	-	-	-	
	Rate of C.difficile infection per 100,000 beddays	NHS Digital	Apr15-Mar16	14.7	14.9	0	66	14.9	-

Domain	Indicator	Source	Latest Date Range	This Years Value	Last Years Value	Best Performance (National)	Worst Performance (National)	National Average	National Target
	MRSA bacteraemias	NHS Digital	Apr15-Mar16	0	0	0	14	2	-
	Rate per 1000 bed days - Patient safety incidents	NHS Digital	Apr15-Mar16	36.9	32.4	-	-	-	-
	Percentage of Patient Safety Incidents that resulted in severe harm or death.	NHS Digital	Apr15-Mar16	0.018%	0.014%	0%	0.063%	0.016%	-
Risk Assessment Framework Indicators	Clostridium (C.) difficile – meeting the C. difficile objective (All)	NHS Digital	Apr16-Mar17	9	16	-	-	-	-
	Certification against compliance with requirements regarding access to health care for people with a learning disability	Trust Board Declaration	Apr16-Mar17	Compliant	Compliant	-	-	-	-
	62 day wait for first treatment from urgent GP referral: all cancers	CWT RETURN	Apr16-Mar17	85.9%	87.1%	-	-	-	85%
	62 day wait for first treatment from consultant screening service referral: all cancers	CWT RETURN	Apr16-Mar17	84.6%	97.4%	-	-	-	90%
	31 day wait from diagnosis to first treatment: all cancers	CWT RETURN	Apr16-Mar17	97.7%	97.6%	-	-	-	96%
	31 day wait for second or subsequent treatment: surgery	CWT RETURN	Apr16-Mar17	91.5%	97.3%	-	-	-	94%
	31 day wait for second or subsequent treatment: anti cancer drug	CWT RETURN	Apr16-Mar17	98.3%	99.3%	-	-	-	98%
	Two week wait from referrals to date first seen: all cancers	CWT RETURN	Apr16-Mar17	93.2%	93.3%	-	-	-	93%

Domain	Indicator	Source	Latest Date Range	This Years Value	Last Years Value	Best Performance (National)	Worst Performance (National)	National Average	National Target
	Two week wait from referrals to date first seen: breast symptoms	CWT RETURN	Apr16-Mar17	96.4%	95.7%	-	-	-	93%
	18 week maximum wait from point of referral to treatment (incomplete pathways)	UNIFY RETURN	Apr16-Mar17	90.8%	90.4%	-	-	-	92%
	Maximum 6-week wait for diagnostic procedures	WEEKLY SITREP	Apr16-Mar17	99.2%	97.1%	-	-	-	99%
	Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	WEEKLY SITREP	Apr16-Mar17	93.8%	93.4%	-	-	-	95%

Yeovil District Hospital considers that the data for Referral To Treatment (RTT) is as described due to inaccurate recording of start dates upon registration. Audit has identified that this has not resulted in any breaches. The Trust is assured that data quality has improved with the implementation of Trakcare in June 2016. The Trust intends to take the following actions to improve the position as follows:

- User training programme
- Review and update of access policy
- Dissemination of standard operating procedures across booking services

Whilst the target for A&E performance was not achieved for the year-end, the auditors sampled 20 records from the reported and provided an unqualified position. The Trust intends to take the following actions to improve this position as follows:

- Review of internal professional standards and escalation triggers
- Focused effort to reduce Delayed Transfers of Care
- Increase in Ambulatory Emergency Care services
- Focus on increasing admission avoidance and discharge to assess models of care

2.12 Data Quality

The Trust's internal clinical coding audit programme for 2016/17 includes Orthopaedics and Emergency Assessment Unit episodes as well as a general mixed sample. The audit has yet to be completed. The Trust was not subject to an external PbR audit during the period.

A review was undertaken by CHKS on behalf of Yeovil District Hospital which examined the clinical coding accuracy of 194 spells for activity between April and June 2016. The areas reviewed were elective and non-elective endoscopy, oral surgery and several areas of trauma and orthopaedics (T&O).

Table 1: Summary findings from the audit

Area	Spells tested	% of spells changing payment	% of spells changing HRG	% clinical codes incorrect
Overall	**194**	**8.2**	**7.7**	**7.5**

The error rate resulted in a gross financial error of £9,690 (2.1%). The net impact of this was a £1,438 (0.3%) over charge to commissioners for the sample audited. The coding accuracy achieved information governance toolkit (IGT) level 3 (good) in one out of four coding indicators and level 2 (adequate) in three areas.

Table 2: IGT levels of attainment

	Primary diagnosis correct	Secondary diagnosis correct	Primary procedure correct	Secondary procedure correct
IGT level 3 requirement	>=95.0%	>=90.0%	>=95.0%	>=90.0%
IGT level 2 requirement	>=90.0%	>=80.0%	>=90.0%	>=80.0%
Yeovil	**93.4%**	**93.3%**	**93.6%**	**86.7%**

The hospital accuracy levels were at Level 2 overall due to errors in primary diagnoses and primary/secondary procedures. Secondary diagnoses accuracy was of a good standard (level 3) with a consistent recording of mandatory co morbidities.

The action plan from last year's audit has been implemented with improvements including extended guided study in T&O post qualification, procedure codes agreed with clinicians for joint use and delivering advice on use of terminology which facilitates precise clinical coding. The completion of clinical coding has also become much timelier with 99% coded by day 3. Further audits will be undertaken in Quarter 1 and Quarter 3 of 2017/18. Additional actions include issue of standard guidance for recording of re-attendance for ambulatory care pathways and guidance for medical staff to improve recording of primary diagnosis.

PbR Audit 2016/17

The Trust was not subject to the Payments by Results clinical coding audit for the reporting period by the Audit Commission however, a PbR clinical coding audit was commissioned to be undertaken by CHKS to provide an independent view on whether data for selected areas accurately reflects patient care and that payment is correct under national rules, this also fulfilled the requirements under IG toolkit. The error rates reported in the latest published audit undertaken in June 2016 for diagnosis and treatment coding were;

From a sample of 198 episodes examined;

Description of code	% Accuracy
Primary Diagnosis	**93.4**
Secondary Diagnosis	**93.7**
Primary Procedure	**93.6**
Secondary Procedure	**88.6**
Health Resource Group	**92.4**

The Trust submitted records during 2016/17 to the Secondary User Services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included a valid NHS number was:

- 99.6% for admitted patient care;
- 99.9% for outpatient care
- 99% for Accident and Emergency Care

The percentage of records in the published data which included a valid General Medical Practice code was:
99.9% for admitted patient care
100% for outpatient care
100% for Accident and Emergency Care

2.13 Information Governance

The Yeovil District Hospital Information Governance Assessment Report overall score for 2015/16 (version 13) was 79% and was graded Green – Satisfactory.

Work is continuing on Version 14, 2016/17 of the Information Governance Toolkit to ensure the Trust continues to meet a level 2, satisfactory score across all 45 recommendations.

The focus of this work is on Information Sharing, Data Quality, Records Management, Asset Management and Corporate Records Management which has been greatly supported by the implementation of our new Electronic Health Records system, TrakCare (supplied by Intersystems) and the formation of a robust Application Support Team.

Part Three: Other Information

3.1 Staff Survey 2016

The 2016 Staff Survey has shown improvements in many areas and whilst there is a lot more to do, we are moving in the right direction and the results are encouraging. Our response rate was 64%.

The results show us that:

- we are getting better at managing our people;
- people feel they are supported by our managers;
- managers act on feedback;
- people feel increasingly valued;
- opportunities for flexible working are good;
- we take an interest in the health and wellbeing of our people.

Key findings include: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion which saw an increase from 86% in 2015 to 88% in 2016; percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months which has deteriorated from 19% in 2015 to 20% in 2016.

We have put in place a comprehensive leadership development process as part of our vision to support and develop our people. The programme involves managers completing a self-assessment tool to help them create an action plan tailored to their own needs.

Managers will be able to select from over 40 courses, some of which address harassment and bullying. As well as self-selection, managers who we consider would benefit from this training, will be asked to attend relevant programmes.

Despite this, the number of staff who recommend Yeovil District Hospital as a place to work has improved since last year, and we remain above average for acute trusts.

However, we are aware that in some areas there is a need for improvement, and this is with regard to the quality of care staff are able to offer, low appraisal rates, opportunities for promotion, effectiveness of reporting procedures, and the levels of physical violence against staff by patients.

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

3.2 Patient Safety

The Trust continues to strengthen and improve the approach to Patient Safety by the appointment of a Clinical Director for Patient Safety to work collaboratively with the Associate Director and Patient Safety Team.

The Trust demonstrates its ongoing commitment to Patient Safety and continues to send delegates to the IHI Patient Safety Officer Training Programme each year. The programme is an accredited, five day intensive residential programme designed to equip front line staff with all the skills they need to improve quality and safety. The Trust has sent twenty staff members to date, including consultants, front line and non-clinical staff, with four more registered to attend in May 2017.

The Sign up to Safety campaign is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating an environment devoted to continuous learning and improvement. This ambition is bigger than any individual or organisation and achieving it

requires us all to unite behind this common purpose. We need to give patients confidence that we are doing all we can to ensure that the care they receive will be safe and effective at all times.

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.

The appointment of a Freedom to Speak Up Guardian will support staff to feel safe to speak when things go wrong and support the Trust ambition to maintain a culture of psychological safety.

Our Patient Safety Improvement plan incorporates national recommendations, including safe staffing levels, and local priorities that reflect our patients' needs. In addition, plans to implement models to provide enhanced seven day services will be a key enabler to preventing admissions at weekends and facilitating discharge improve the experience for patients and ensure timely access to diagnosis and treatment. In addition, improving access to high quality end of life care will be a priority.

We implement and monitor the Improvement Plan through our Harm Free and Patient Safety Groups and by progress against CQUIN targets:

- Safer Medicines Group;
- Recognition and Rescue Group (AKI and Sepsis);
- Pressure Ulcer Steering Group;
- Falls Prevention Group;
- Peer Review Groups;
- Safety Thermometer.

We tackle our proposed projects by using appropriate quality improvement methods, such as 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 Clinical Governance Assurance Committee and the Patient Experience Working Group.

Initiatives to reduce avoidable harm include:

3.2.1 Reducing Patient Falls

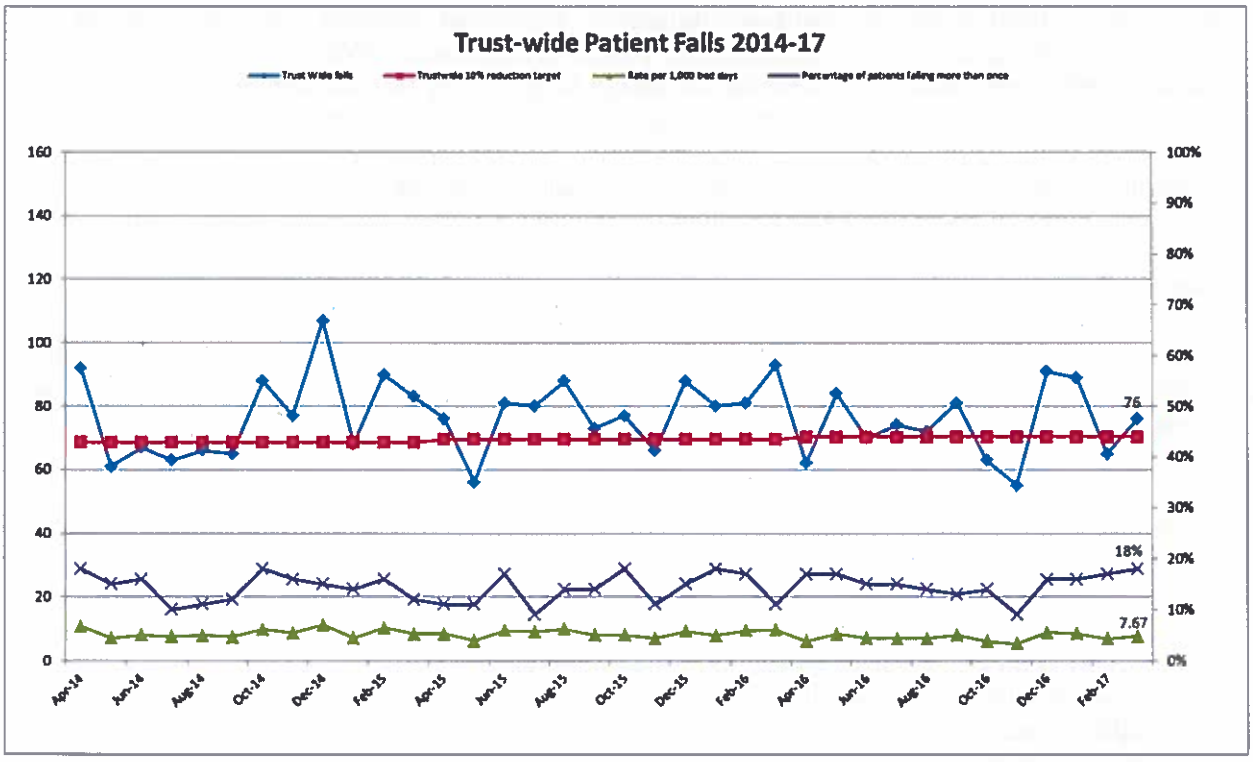
Some patients are at high risk of falling, either as a result of their rehabilitation or condition, and it is recognised that this causes anxiety, loss of confidence and in some cases serious injury to patients. The length of stay for patients who have fallen whilst in hospital is often increased as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

The Trust is working hard to meet its commitment to reduce falls resulting in harm by 50% by 2017 (Grade 3 and above) and has recently appointed a Falls Prevention Practitioner. Older people admitted with falls are being offered home hazard assessments upon discharge from hospital. Intentional Rounding has been implemented and training has been provided via Snack box training

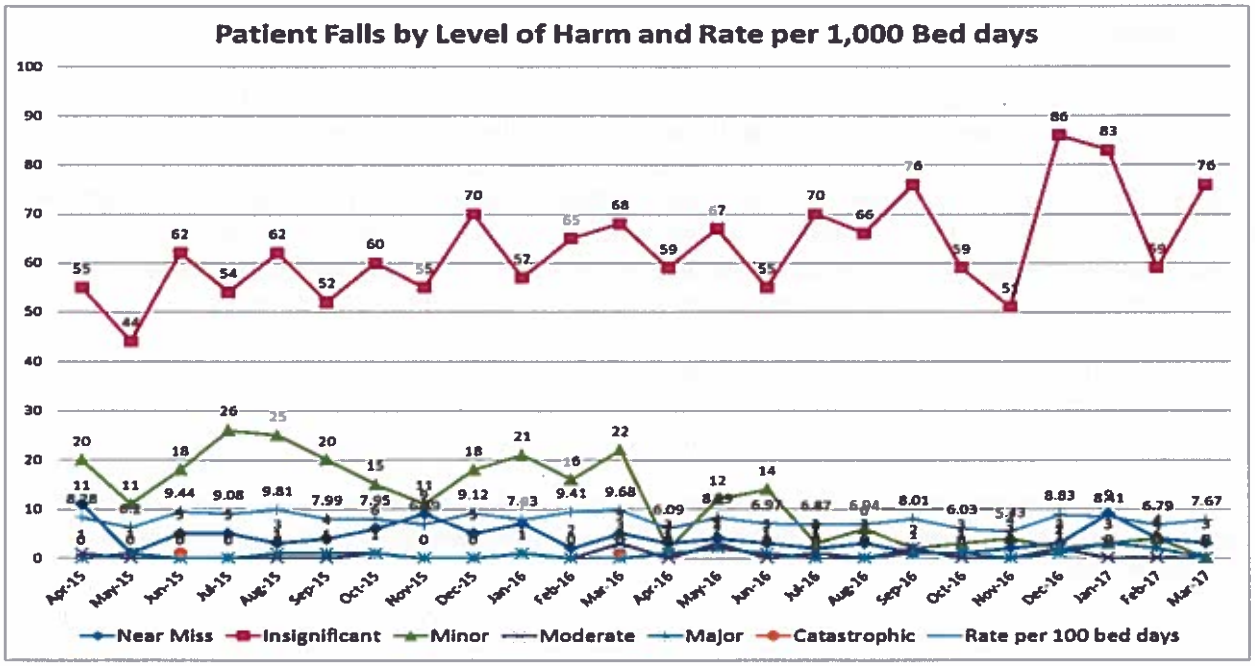
and was well received. The Trust continues to audit the level of compliance with the multi-factorial risk assessment in patient areas in order to improve patient safety and outcomes.

In the latter stages of the year an initiative called TAG Care was implemented on one ward to reiterate the multi-disciplinary approach to falls prevention. Patients deemed to be at particular risk are nursed in one of two high visibility bays and staff tagged to ensure continued presence and oversight to prevent accidental falls. This supports the assessment of risk by physiotherapists, pharmacists and medical staff as well as nursing to develop patient centred care plans. This approach will now be rolled out across all relevant inpatient areas.

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



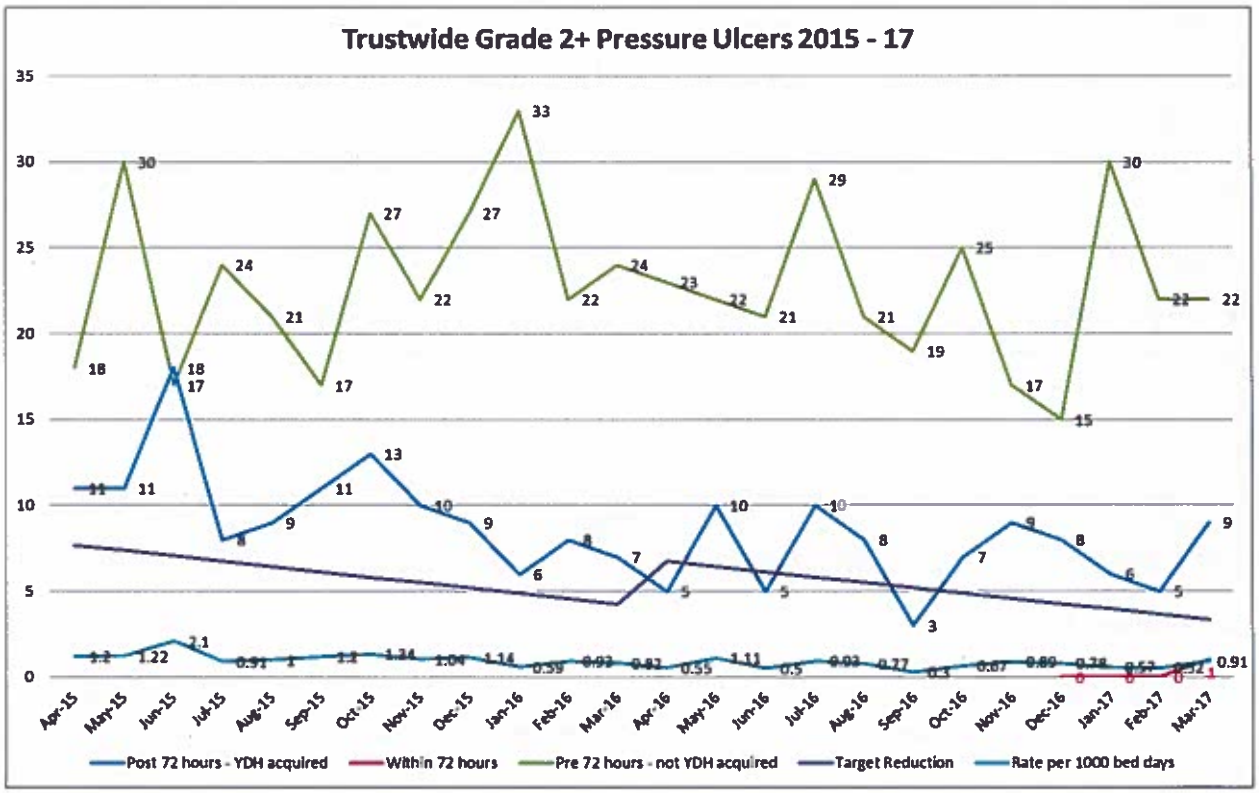
Levels of Harm are calculated using the National Patient Safety Agency (NPSA) risk matrix and in accordance with national guidance. Data is extrapolated from the LRMS and reported as incidence and rate of falls per 1,000 bed days as detailed below.



3.2.2 Pressure Ulcers

The Trust is committed to reducing preventable pressure ulcers and successfully achieved a 62% reduction in hospital acquired incidents (Grade 2 and above) of 85 incidents compared to the 2012/13 baseline (221) by 2017.

Grading of pressure damage is consistent with national guidance and in line with the South West Regional Framework for Pressure Ulcers. Work is also undertaken across Somerset providers to ensure consistency with reporting.



3.2.3 Sepsis

An estimated 44,000 people a year die from Sepsis in the UK – it is suggested that with prompt recognition and treatment around 1/3 of these deaths could be prevented. For Yeovil District Hospital this could be 2-3 patients a week. However, this is only part of the story - over 120,000 people in the UK develop Sepsis a year. Most of these will survive, but many will be left with debilitating physical and psychological long term problems. The Trust's aim is to reduce Sepsis Morbidity and Mortality by 50% by 2017 as detailed in the Patient Safety Improvement Plan. In addition, the national Sepsis CQUIN details definitions and reporting arrangements

At Yeovil District Hospital we are working hard to improve our practice – the commitment and support from the staff has been invaluable. Paediatric and Maternity teams are working with us to implement their own systems to aid prompt recognition and treatment.

Although we are not hitting the 60min from arrival target in ED consistently, the time to antibiotics is reducing and over the last quarter all were within 120 mins which is a significant improvement on two years ago.

Below are the results for the two national Sepsis CQUINs for 2016/17.

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

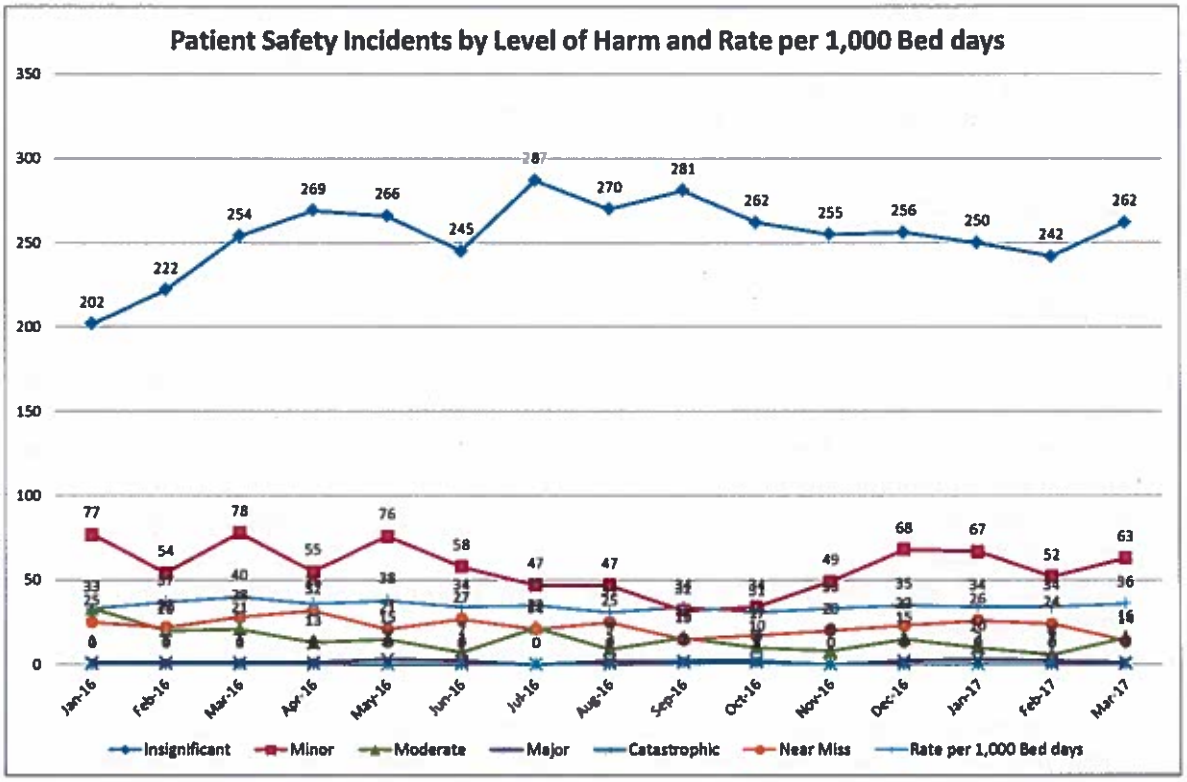
3.2.4 Patient Safety Incidents

During 2016/17 there were 3,411 patient safety incidents classed as no harm/near miss in line with national guidance. There were 167 patient safety incidents classed as moderate, major or catastrophic, of which twenty were major and two were catastrophic. 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 the patient safety culture and a reduction in incidents resulting in harm.

The Trust embraces openness, learning from incidents and complaints and listening to patients, carers and staff and taking action to improve patients' safety.

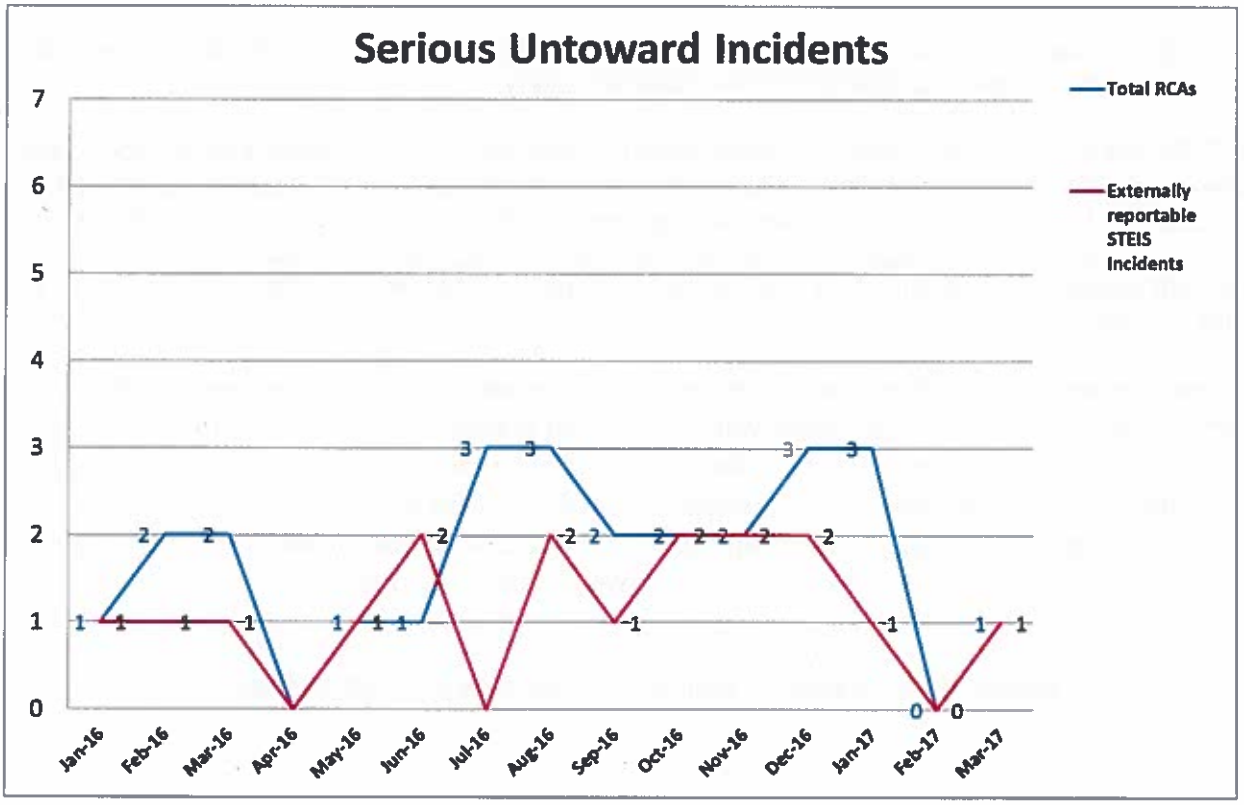
The Trust has a positive approach to incident reporting and actively encourages staff to report near misses and patient safety incidents. During the year, the frequency of incident reporting has increased by 1.76% which has assisted with greater ability to identify trends. All reports are reviewed by a senior manager with comprehensive investigations conducted into the more significant incidents. The aim is to ensure that lessons are learned and then shared widely to reduce the likelihood of a recurrence.

The total number of incidents and accidents reported increased by 408. There were 6,828 reported incidents in 2016/17 compared with 6,420 in the previous year. A measure of organisational safety is a high level of incident reporting but a low level of harm; this allows early identification of risk to the safety of our patients before an adverse event occurs. It should be noted that this data is accurate up to 21 April 2017. The following chart shows the Patient Safety incident data for 2016/17 and shows the different levels of harm reported.



3.2.5 Serious Incidents

A total of 97 concise or safeguarding investigations were commissioned in 2016/17. Of these 17 required a Comprehensive Root Cause Analysis and 14 met the definitions of a Serious Incident Requiring Investigation, in accordance with national definitions and guidance, and were reported to Somerset Clinical Commissioning Group. All 17 meet the threshold for Duty of Candour which was complied with accordingly.



3.2.6 Duty of Candour

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

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

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

3.2.7 Preventing Venous Thrombo-embolism

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 patients attending the Emergency Department. We audit compliance with these procedures and if a patient develops a pulmonary embolism or deep vein thrombosis 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 and the appropriateness of the existing exclusion criteria.

Compliance with VTE Risk assessment and prophylaxis is a key patient safety measure and a nationally reported key quality indicator with a National Target of 95%. The Trust was achieving 95.45% from April 2016 until June 2016 when a new electronic patient record system (Trakcare) was introduced. The change in process led to a reduction in recording of VTE Risk assessment with a decrease to 74.92%. Action was taken to improve recording with a subsequent increase to 90.6% of patients being risk assessed within 24 hours of admission at the end of quarter 4 and an overall year end position of 96%.

In the first 3 quarters of 2016/17 there were 7 cases of avoidable VTE reported. (Due to the collection period with data for patient developing a VTE within 90 days following discharge quarter 4 data is not yet available). In these cases investigations have shown either a failure in assessment or in the provision of preventative measures, although it cannot be definitively known whether this group of patients would have developed the thrombosis due to other contributory factors. Improvements include review of agreed cohorts for assessment e.g. orthopaedic outpatients with risk factors, redesign of drug charts to improve oversight of prophylaxis and implementation of a daily ward round checklist of junior doctors.

3.2.8 Medication Errors

The number of medication incidents reported by Yeovil District Hospital staff has increased during 2016/17 as staff groups are being encouraged to report all incidents to enhance our understanding and learning. This is reflected in the Department of Health's "Learning from Mistakes league" where Yeovil District Hospital has been ranked as having "good levels of openness and transparency." The league table has been drawn together by scoring providers based on the fairness and effectiveness of procedures for reporting errors; near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their Trust.

The number of medication incidents resulting in patient harm remains low at 1.5%. This compares favourably with recent data from the National Reporting & Learning System which shows that 81% of reported incidents result in no harm.

The Trust's Safer Medicines Group continues to monitor all medication related incidents, Drug Safety Updates and relevant Patient Safety Alerts. The group is also responsible for implementing changes to the prescribing, administration and handling of medicines within the Trust in order to minimise risk and to improve patient safety.

In response to reported incidents, several initiatives have been implemented including an amendment to the Diabetes Prescribing and Administration chart, to clarify potassium additions; the production of Intravenous Aminophylline and Phenytoin Prescribing Guides; and the approval of an Enabling Policy allowing pharmacists to change/amend prescriptions within certain defined parameters. It is hoped this will help reduce missed doses, avoid medication errors and improve patient safety.

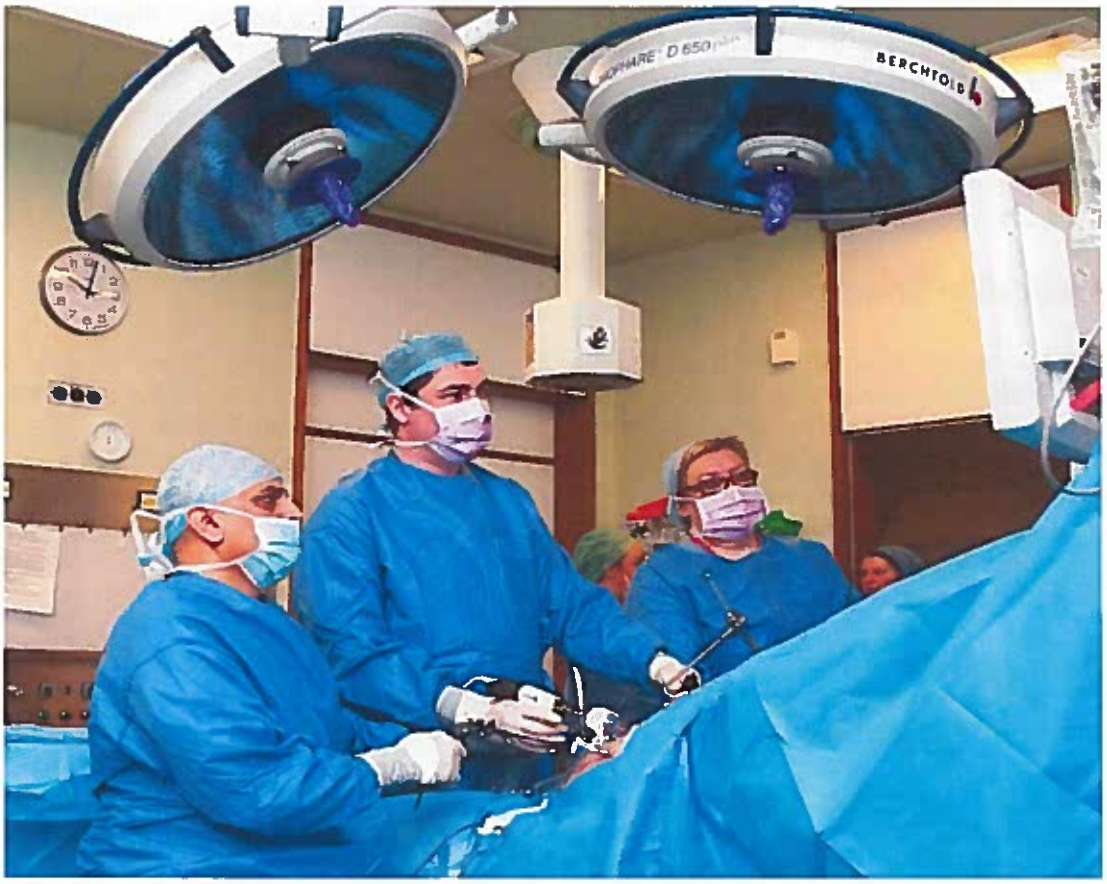
Several Medication Safety Bulletins have been published following reported incidents. These have included a warfarin bulletin reminding prescribers of the potential factors associated with developing high INRs, and another advising on the safe and unambiguous prescribing of 24 hour

continuous infusions. Further bulletins are planned to raise awareness of safe prescribing of both methotrexate and intravenous paracetamol.

3.2.9 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 two Never Events during 2016/17 in relation to wrong site surgery; excision of incorrect side of toenail in November 2016 and wide excision of previous mole excision on incorrect side in December 2016. Full formal investigations identified all relevant learning, no consistency in findings and actions to prevent similar occurrences. Work is underway with the Day Theatre and Surgical teams on increasing understanding of human and contributory factors and use of standardised processes to ensure patient safety.



3.2.10 Learning Lessons

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

- TAG Care has been implemented with a view to reducing the risk of inpatient falls;
- We have purchased additional specialist equipment which includes new mattresses to improve pressure relief to prevent skin damage. We continue to review equipment to ensure the best possible outcomes for patients;

- The Trust uses patient name boards which include visual cues and prompts to ensure safety risks are communicated to all staff;
- The creation of a new Multi-Disciplinary Assessment Record including a patient centred care plan;
- Developing care plans for roll out across the Trust for every patient;
- Creation of a new fluid balance chart to improve prescribing practice.

3.2.11 Patient Safety Thermometer

The Trust continues to undertake the Patient Safety Thermometer on a monthly basis. This is a point prevalence survey of all inpatients undertaken on a single day in a month, which provides a temperature check of the quality and safety of care and determined by local systems and process in providing a care environment. All patients are assessed for evidence of skin damage, falls, infections associated with having a catheter and for VTE (Blood clots). The data is published nationally and used to understand the progress the Trust is making in reducing avoidable harm to patients. It continues to be a successful, proven method of capturing real-time data. The following graph highlights the consistent level of harm free care provided by the Trust.

Senior nurses continue to meet once a month to undertake the survey and to share learning, identify areas for improvement and discretely respond to areas of concern. The Trust also conducts Peer Review on the same day which can provide instant feedback to senior nursing staff regarding their wards or areas.

3.2.12 Maternity Safety

Our emergency caesarean section rate was 15.5%, representing a small reduction from 15.7% compared to 2015/16. This is comparable with rates across the Southwest region.

Maternity safety and performance is reviewed using the regional dashboard and reported to the Patient Safety Steering Group, CCG Maternity Forum and via Clinical Quality Review Forum. The Better Births programme and Maternity Safety Collaborative will be key areas of focus for the team in 2017/18 and beyond.

3.2.13 Patient Safety Alert Broadcasts (SABs)

Safety Alert Broadcasts are used as a way to communicate particular risks that have been identified nationally and which require attention from organisations to mitigate risks of occurrence. Compliance is monitored monthly by the Patient Safety Steering Group with no outstanding safety alerts at year end.

3.3 Clinical Effectiveness

We have a number of processes for understanding the effectiveness and monitoring to ensure the care we provide follows national best practice

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.

Over the last year the committee also received monthly reports from the CRAB intelligence system. Doctor Foster takes diagnostic data from the Trust for comparison nationally, measuring clinical outcomes and providing dashboards for key indicators of quality and efficiency. This analysis will in future be taken over by CRAB (Copelands Risk Adjusted Barometer). This new company will provide a similar level of data analysis allowing us to appreciate at an early stage where problems may be developing. We will also be able to identify trends within teams as well as trust wide.

Over the year we have reviewed specific areas of practice as a result of the Doctor Foster reports highlighting where we have been an outlier, either for mortality, length of stay or the number of readmissions. We have undertaken reviews for several groups of patients including the number of readmissions reported following childbirth, the number of patients admitted with an initial diagnosis of head ache and a comparison of the number of deaths on weekdays and weekends.

In all cases where a higher than average figure was reported a review was undertaken of the group of patients involved. This looked at the accuracy of clinical coding and also the clinical care and management to establish the cause of the higher figures. The reviews have not identified any omissions of care or poor management.

We do know that the way a patient's diagnosis is documented has a direct bearing on the way this data can be used and we have worked to ensure what is written in the clinical records can be effectively captured to ensure the data is accurate. The move towards electronic records will help with the issues identified and help reduce the potential for coding anomalies.

3.3.1 Mortality and SHMI

The HSMR for the Trust has been closely monitored throughout previous years with the Hospital Standardised Mortality Ratio (HSMR) within the expected range compared to hospital trusts nationally. With the change from Dr Foster to CRAB and the introduction of a new data analysis system over the year 2016/17 mortality data is now presented in a different format with o/e ratios and SHMI being monitored. This comparative data will continue to allow us to benchmark with other Trusts of a similar size using these systems.

National Quality Board Guidance on Learning from Deaths (March, 2017) requires enhanced reporting of case note reviews during 2017/18. Focus will be given to standardising the review of deaths using a judgement review tool (Royal College of Physicians) and work is underway to ensure compliance with review and reporting requirements accordingly. Information will be reported and published quarterly highlighting key areas of learning.

3.3.2 Patient Reported Outcome Measures

Patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves.

The Trust has been participating in the National PROMs programme since it started in 2009 for hip and knee replacement and inguinal hernia repair.

Due to the time period collecting the data and how it is linked with Hospital Episode Statistics (HES) data at the Coordination Centre there is a delay before the finalised data is available.

A new system for capturing PROMS electronically has been introduced in 2016/17. This will enhance the process for mandated PROMS and allow the Trust to capture patient measures from a wider group of patients

The following table shows the key findings from the audit and covers the period 1 April 2015 to 31 March 2016 showing an improvement in all 3 procedures undertaken by the Trust:

Figure 3: Adjusted average health gain on the Oxford Hip Score / Oxford Knee Score by procedure

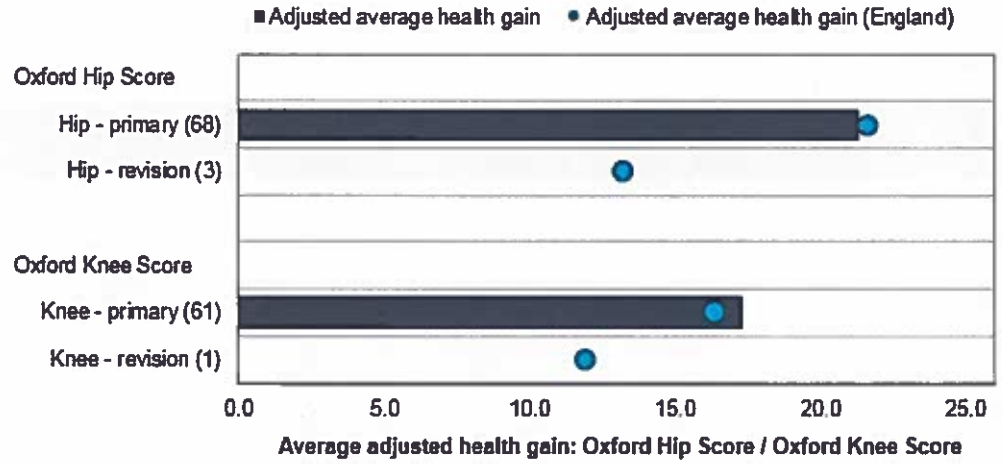
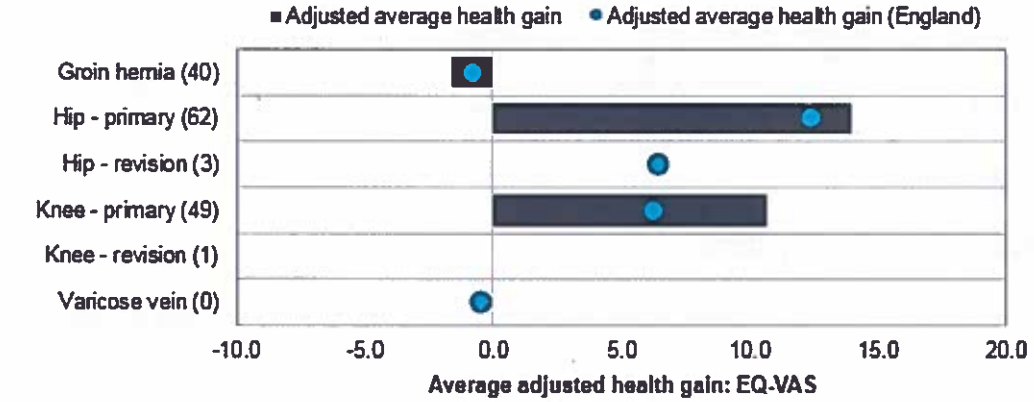
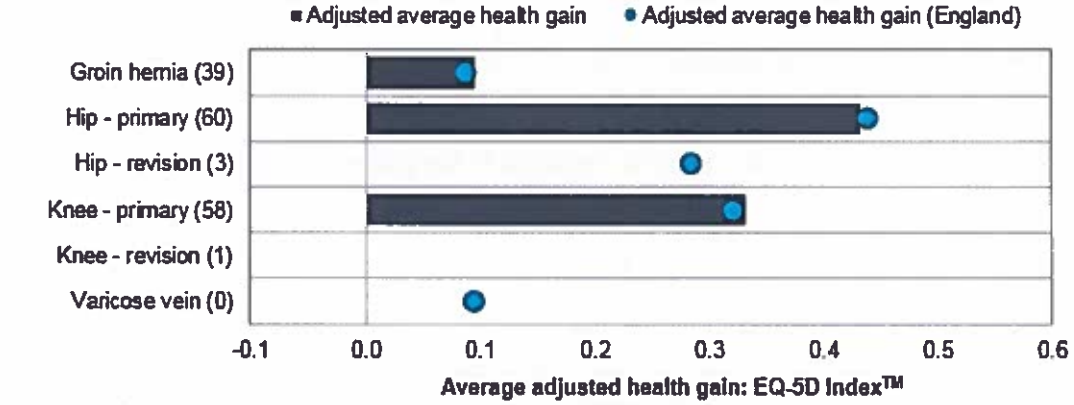


Figure 2: Adjusted average health gain on the EQ-VAS by procedure



Adjusted average health gain

Figure 1: Adjusted average health gain on the EQ-5D™ Index by procedure



3.3.3 Ensuring Compliance with NICE Guidance

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

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

Guidance Type	Publication	Applicable	Compliant	Partially Compliant	Non - Compliant	Under Review
Clinical Guidelines	Total No.	121	88	32	0	1
	In last year	0				
NICE Guidelines	Total No.	35	8	12	0	15
	In last year	28	6	8	0	14
Technology Appraisals	Total No.	221	210	0	0	11
	In last year	42	31	0	0	11
Medical Technology	Total No.	8	6	1	0	1
	In last year	2	0	1	0	1
Diagnostic	Total No.	6	4	1	1	0
	In last year	1	0	0	1	0
Interventional Procedures	Total No.	27	25	0	0	2
	In last year	2	1	0	0	1
Public Health	Total No.	31	23	4	0	4
	In last year	0				

3.4 Patient Experience

3.4.1 National Inpatients Survey 2016

The findings from the 2016 Inpatient Survey were received from the Picker Institute in January 2017. A further public report was received from the CQC in February 2017 included benchmarks against all NHS Trusts.

This annual survey asks the views of adults who had stayed at least one night as an inpatient during the month of July 2016. 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. 1,185 were eligible for the survey, of which 537 returned a completed questionnaire, giving a response rate of 45%.

The 2016 survey has highlighted the many positive aspects of the patient experience, including:

- Overall: 81% rated care 7+ out of 10;
- Overall: treated with respect and dignity 83%;
- Doctors: always had confidence and trust 80%;
- Hospital: room or ward was very/fairly clean 98%;
- Hospital: toilets and bathrooms were very/fairly clean 95%;
- Care: always enough privacy when being examined or treated 90%.

Compared with the results from the 2015 survey, the Trust has significantly improved patient facilities with fewer patients using bath or shower areas that were shared with the opposite sex.

When reviewing the Trust's results against the Picker Average (results compared with the 83 other trusts that commissioned Picker to run the survey), the Trust scored better than average for the following questions:

- Planned admission: not offered a choice of hospital;
- Hospital: patients in more than one ward, sharing sleeping area with opposite sex;
- Hospital: food was fair or poor;
- Hospital: not offered a choice of food.

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

- Admission: had to wait long time to get to bed on ward;
- Care: wanted to be more involved in decisions;
- Care: could not always find staff members to discuss concerns;
- Care: not always enough emotional support from staff;
- Surgery: Anaesthetist/other members of staff did not fully explain how I would be put to sleep or control pain;
- Surgery: results not explained in clear way;
- Discharge: not fully told side effect of medication.

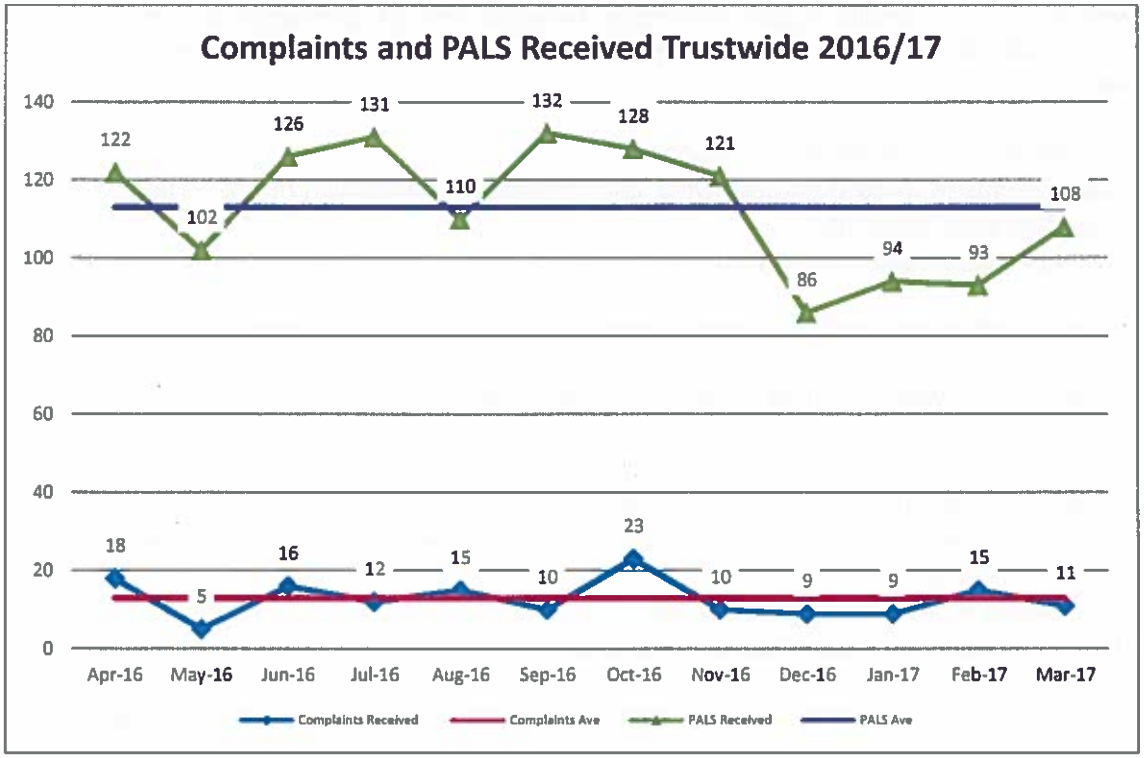
The Trust is aware of the improvement needed from the results of the survey and will be working closely with the patient experience team, nursing, doctors and business managers to ensure improvement are made in these key areas.

3.4.2 Patient Feedback, Complaints and PALS

The Patient Experience Team provide a seven day service which is of benefit to patients, relatives and staff, with one member of the team being available between the hours of 1 and 5 pm on both Saturdays and Sundays. These hours have been specifically allocated to meet the needs of any bereaved relatives whose loved ones have died over the weekend, but also to be available for relatives, particularly those who are visiting from a distance and are only able to attend at the weekend.

The Patient Experience Committee was revised and became the Patient Experience Working group during 2016/17. This was made up of senior staff from around the Trust looking at how to ensure a good experience for all of our Patients and relatives. The Patient Voice Group and their "Your Care" questionnaires are overseen by the Patient Experience Team and the Patient Experience Manager attends all Patient Voice meetings. This feedback from our Patient Voice Group continues to be highly valuable and steps have been taken during 2016 to 2017 to ensure that the necessary improvements and actions are in place following feedback from the "Your Care" questionnaires and complaints. During 2016/17 our Friends and Family test continued to be captured with "IWant Great Care" with the full year average 92% likely to recommend.

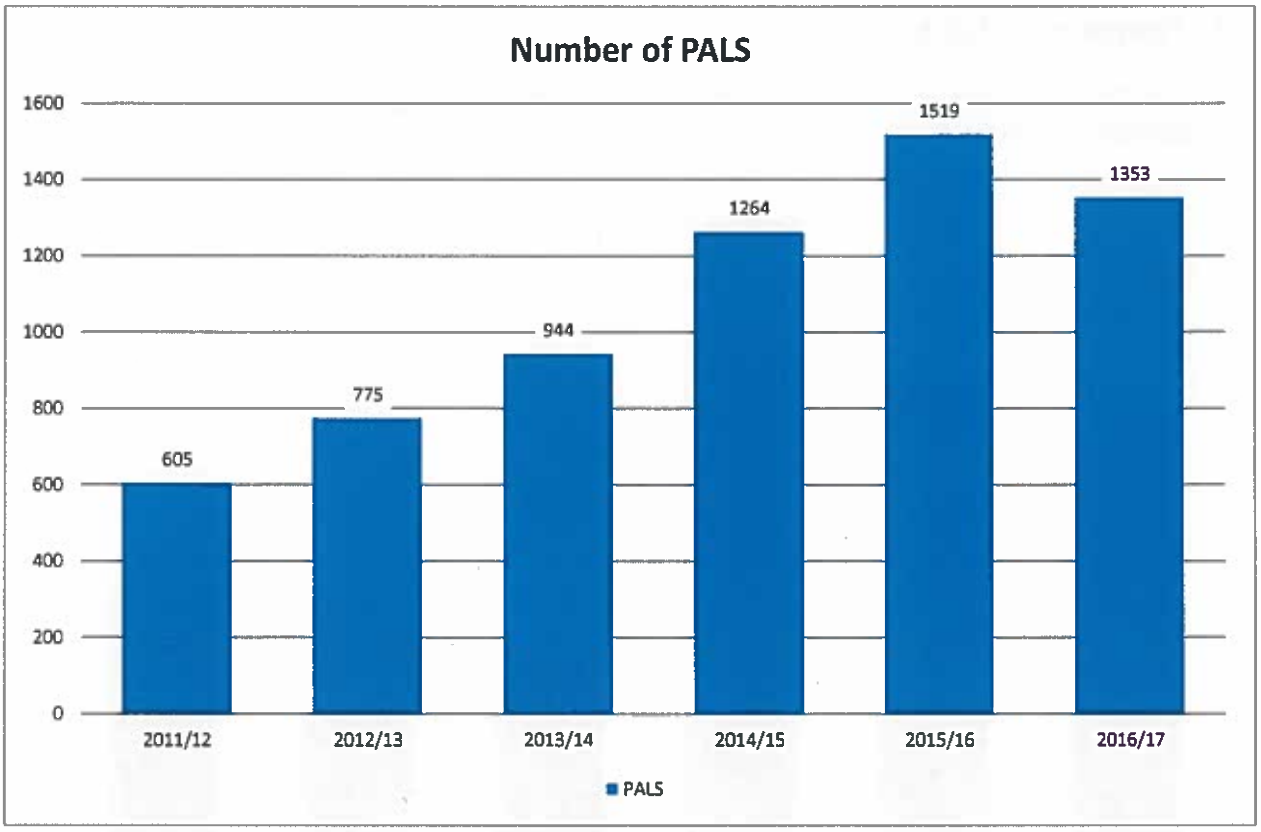
Complaints and enquiries to the Patient Advice and Liaison Service are outlined in the following graph:

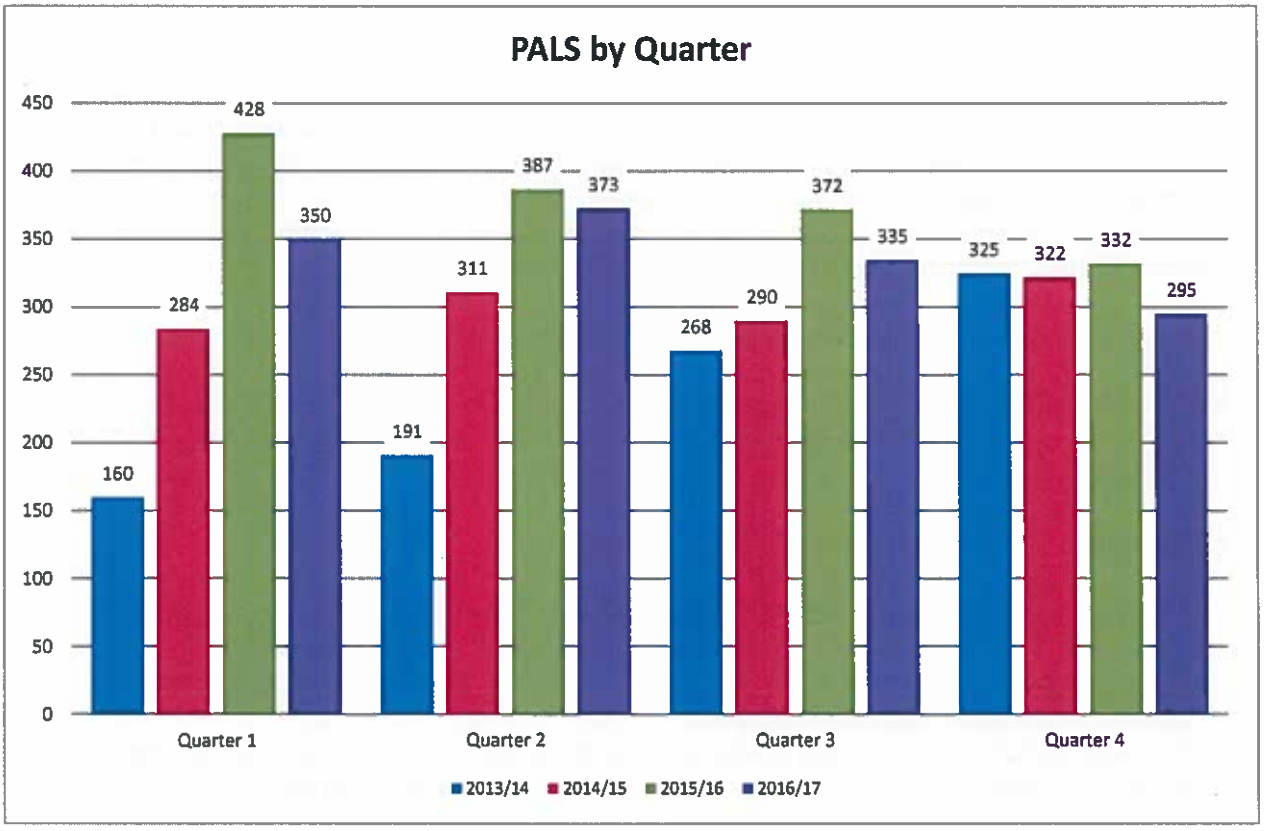


3.4.3 Patient Advice and Liaison Service

The PALS service took 350 PALS concerns during the first quarter and 373 during quarter 2, 335 during quarter 3, and 295 during quarter 4. Details of these are reported monthly to the Strategic Business Units.

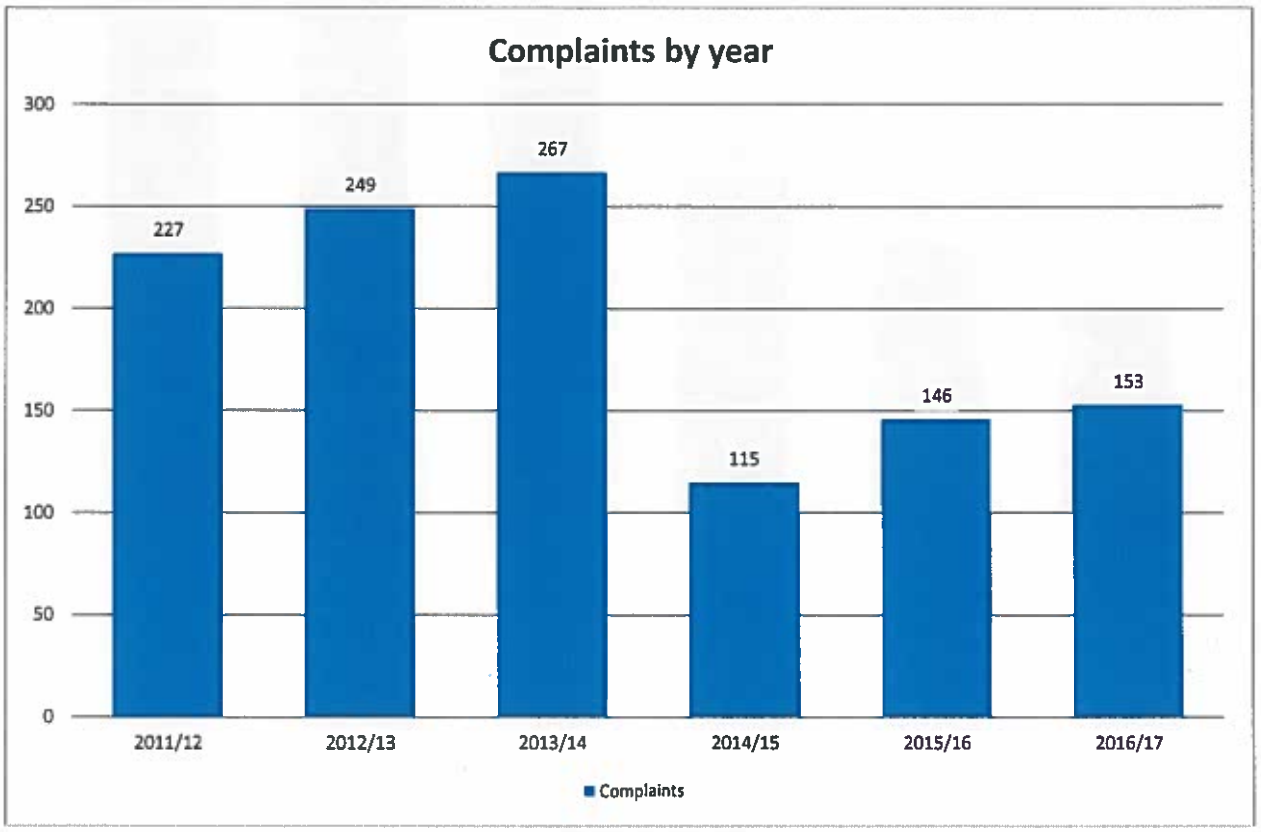
Whilst previously, conciliation meetings were largely conducted as a result of a formal complaint process, a significant number of conciliation meetings now occur as a result of PALS enquiries and bereavement concerns raised when families are collecting a death certificate from the bereavement service.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


Number of PALS
1600
1400
1200
1000
800
600
400
200
0
605
775
944
1264
1519
1353
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
PALS


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

3.4.4 Formal complaints

There were 39 formal complaints received during Quarter 1, 37 during Quarter 2, 42 during Quarter 3, and 35 during Quarter 4.



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

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

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

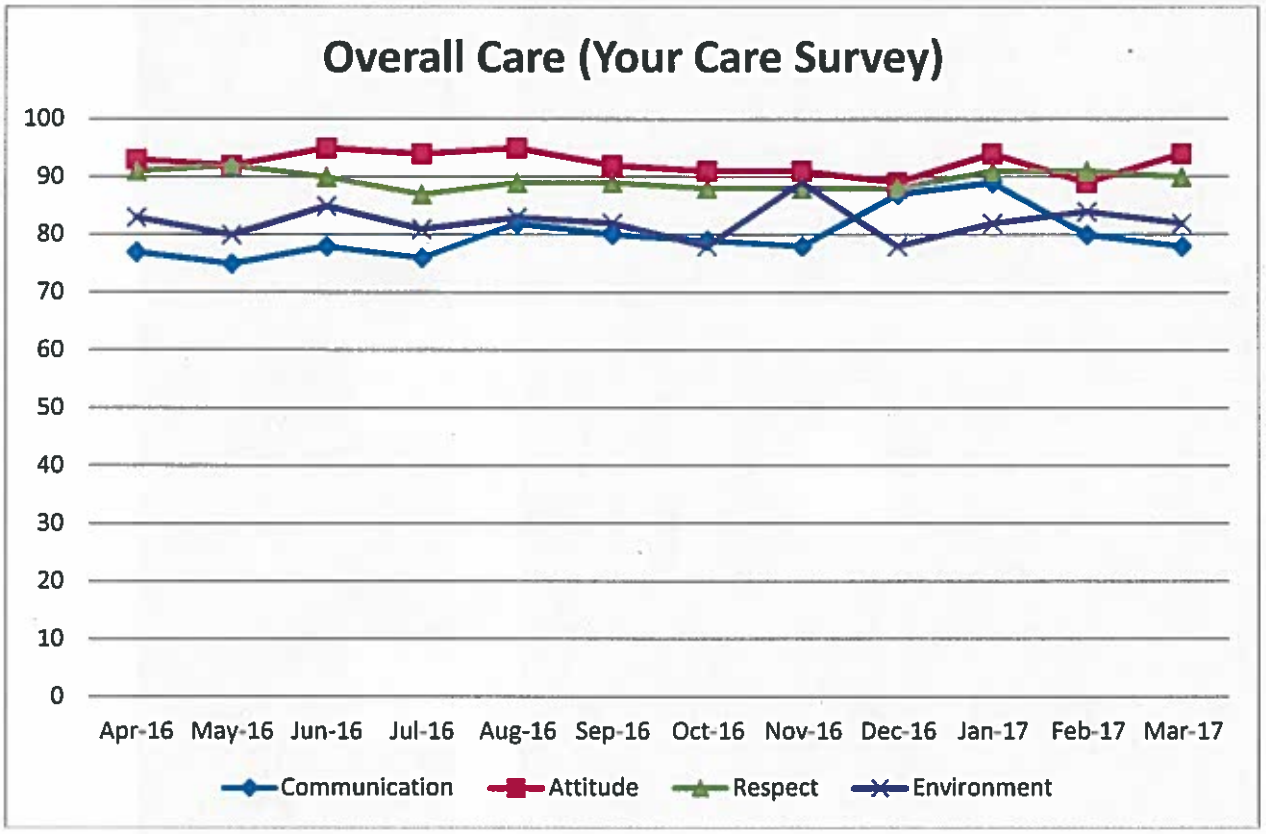
3.4.5 Changes resulting from feedback

- Training took place for key staff with regard to how to assist patients with sight impairment;
- Hand over to ward staff when patients are transferred from ITU was enhanced;
- The number of trained staff in the ED Department competent for male catheterisation, was reviewed and additional training given;
- The Resuscitation Officer was asked to reiterate to the Junior Doctors during training the correct procedure when completing DNR status, especially in terms of including family members in the decision;
- Oncology specialist input to patients with cancer of unknown primary (CUP) has been clarified;
- Assistance for patients with dementia attending the outpatient department is now in place.

3.4.6 Patient Feedback Indicators / Patient Surveys

Your Care Questionnaires

January saw 91 questionnaires completed with 88 during February and 77 in March (facilitated by the PPI members) on the inpatient wards. The following chart shows how respondents rated their overall care.



The Trustwide dashboard demonstrates the full Your Care questionnaire findings. This provides the percentage of patients that answered 'yes' to each question. The benchmarks that have been applied are ≥90% = green, between 75% and 89% = amber and ≤74 = red. The letters down the left hand column indicate whether the question falls within an iCARE category.

A key priority from patient feedback will be the engagement and involvement of patients in their care planning and this is reflected in the Trust quality priorities for the year ahead.

iCARE	Question	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
A	Were you made to feel welcome when you were first admitted to the ward?	93	94	96	96	98	93	93	93	89	94	94	97	94
A	Have staff introduced them to you before treating or caring for you?	90	87	93	88	92	86	85	86	84	92	82	94	88
	Have you received pain relief, if needed in a timely manner	98	98	96	92	97	94	92	92	89	91	89	100	94
C	Have staff valued your opinion regarding your condition/treatment	88	82	93	85	87	78	83	85	88	88	90	84	86
R	Have you been asked how you would like to be know whilst on the ward	86	89	82	81	82	86	85	81	90	90	86	88	86
R	Have you ever been made to feel a nuisance?	96	95	98	93	95	91	91	95	85	92	96	97	94
E	During your time in hospital have you felt safe?	97	98	99	97	97	95	96	99	92	95	96	94	96
E	Have you ever been bothered by noise at night?	73	64	72	72	69	66	61	78	66	71	76	67	70
E	When you have used your call bell or asked for help, have staff responded as quickly as you would like them to?	79	77	85	75	83	84	77	90	77	81	79	88	81
C	If you have raised any concerns with staff, have these been followed up?	82	87	86	86	99	88	85	91	89	93	77	76	70
A	Do you have confidence in the members of staff providing your care	96	94	97	98	97	98	95	94	94	96	90	93	81

iCARE	Question	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
C	Have you had enough time to discuss your current treatment and symptoms with a doctor	86	78	82	83	87	86	87	88	86	83	82	86	85
C	Have staff explained your condition and treatment in a way you can understand	89	84	85	84	90	93	86	93	85	91	72	83	86
C	Have you been involved in the planning of your discharge from hospital	42	42	46	41	49	54	54	35					45
	Were you aware when the doctor's ward rounds took place	53	41	58	61	66	65	64	72					60
	Were you satisfied that you were involved/engaged in the process	82	71	83	84	75	81	89	88					81
	Are you happy with the current visiting times	96	97	97	96	97	100	98	99					98

The table below presents a summary of the Your Care questionnaires based on the iCARE categories.

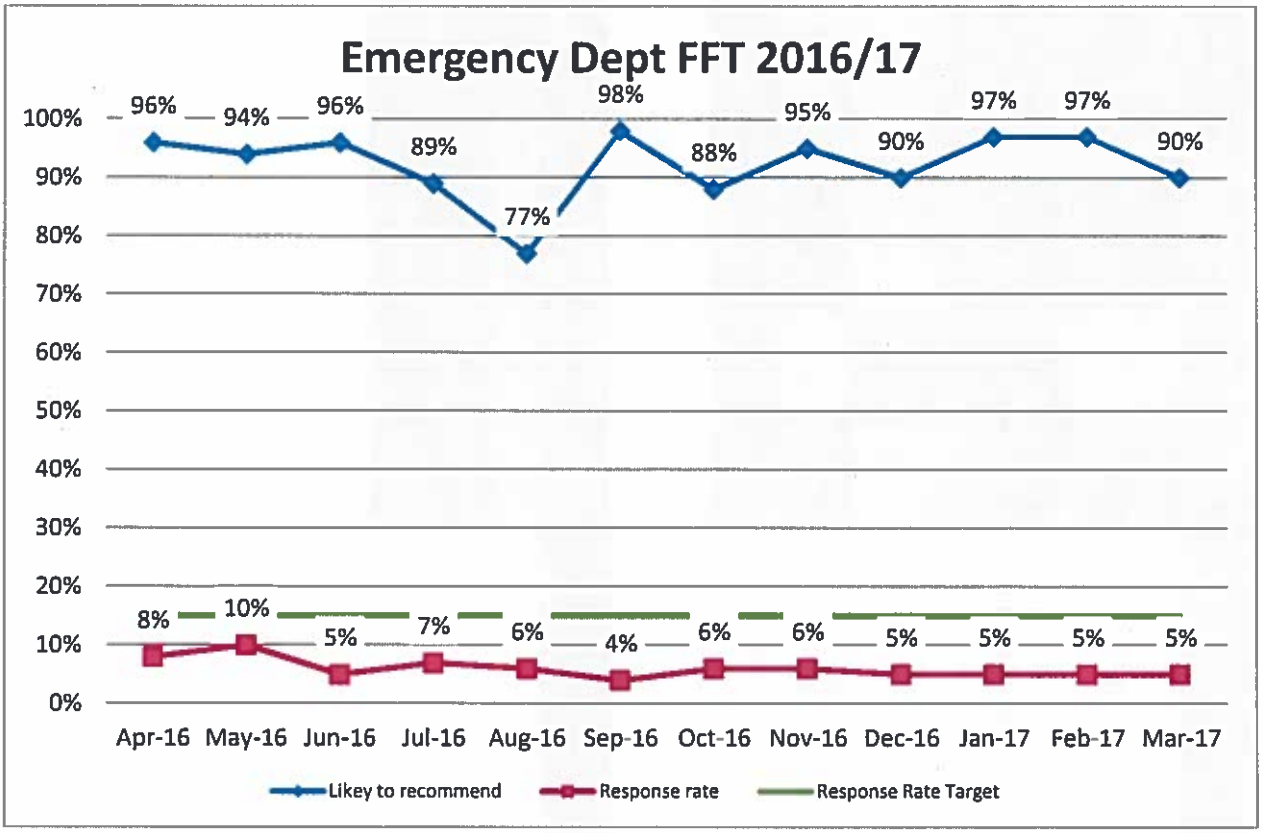
iCARE summary	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Communication	77	75	78	76	82	80	79	78	87	89	80	82	78
Attitude	93	92	95	94	96	92	91	91	89	94	89	95	94
Respect	91	92	90	87	89	89	88	88	88	91	91	93	90
Environment	83	80	85	81	83	82	78	89	78	82	84	83	82

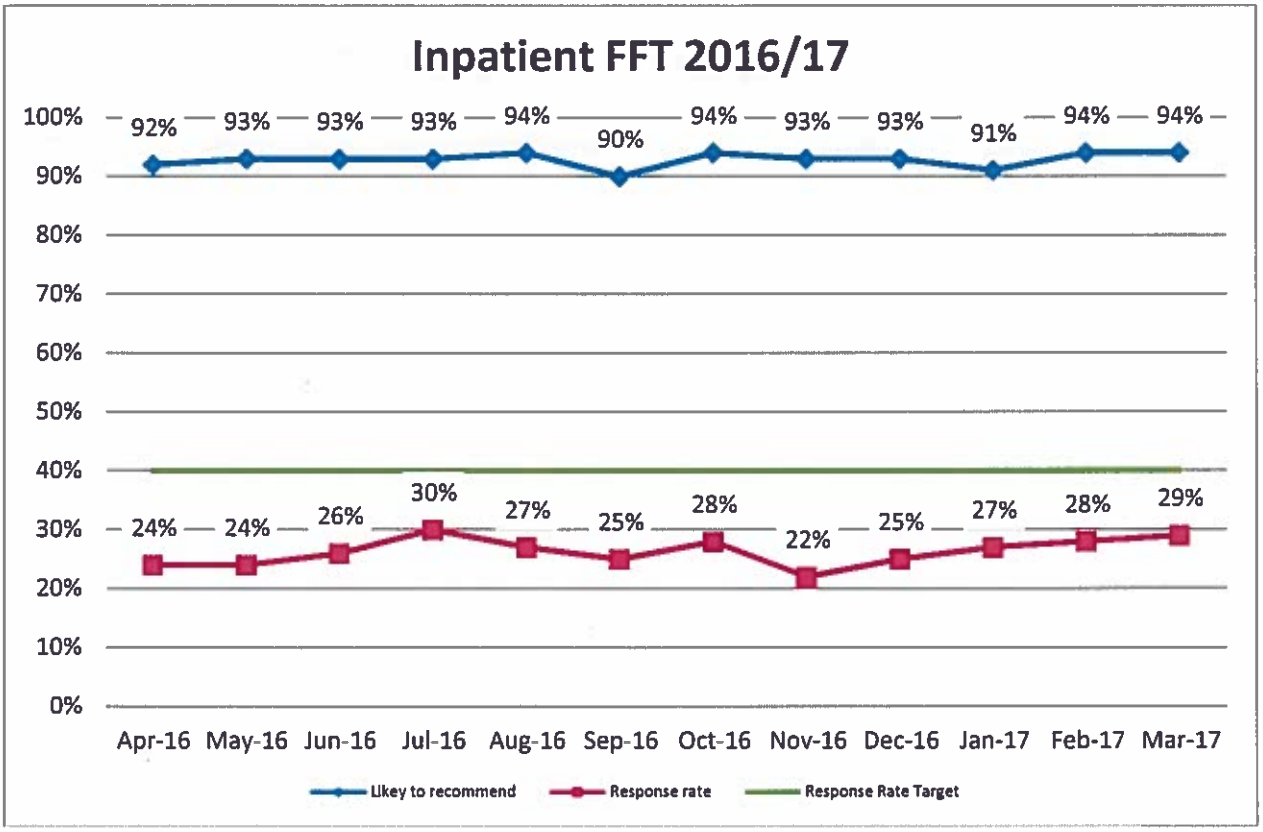
3.4.7 Friends and Family Test

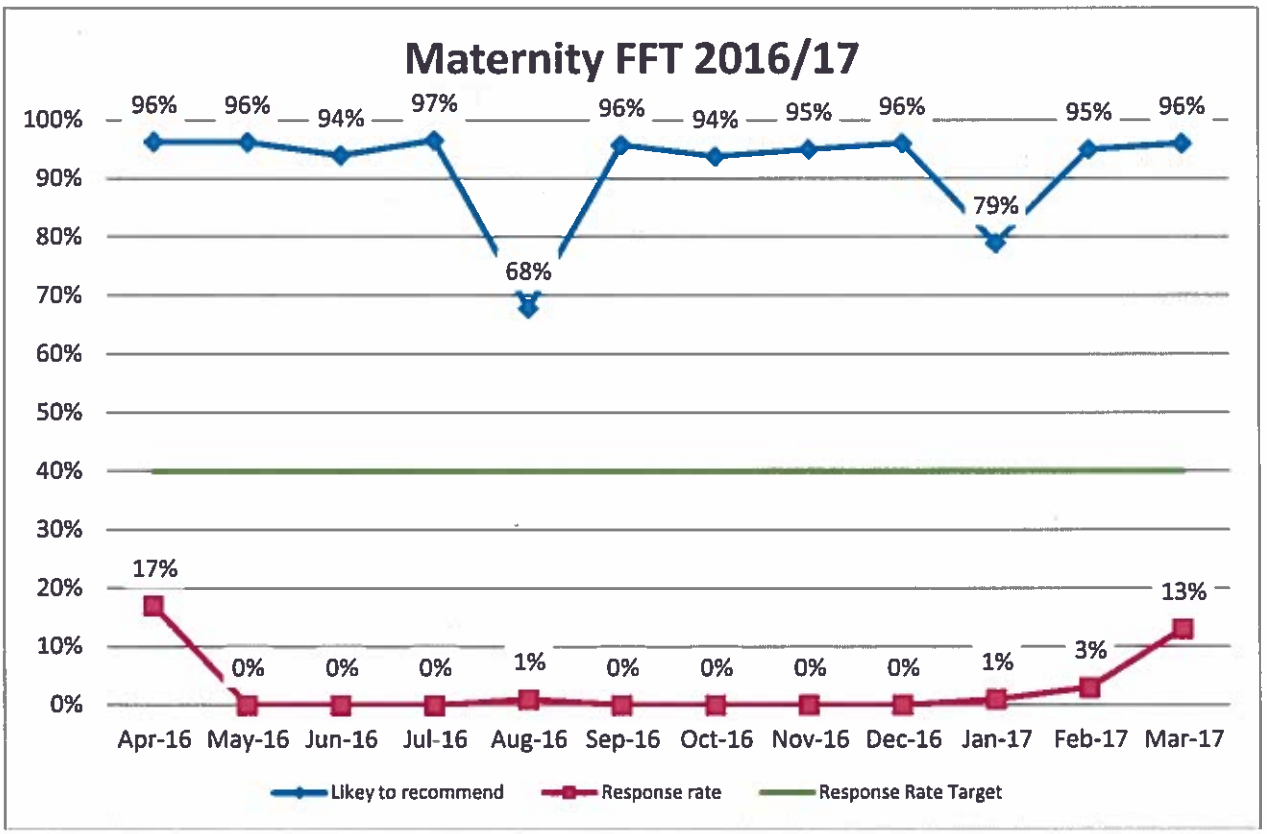
In January the Trust collected 1486 Friends and family test surveys and then increased this number to 1617 in February, there was a further increase in the response rate to 1666 in March. The Friends and Family Test (FFT) is one of the questions within the survey is collected from the inpatient wards, emergency department, maternity unit and outpatient clinics for national submission each month.

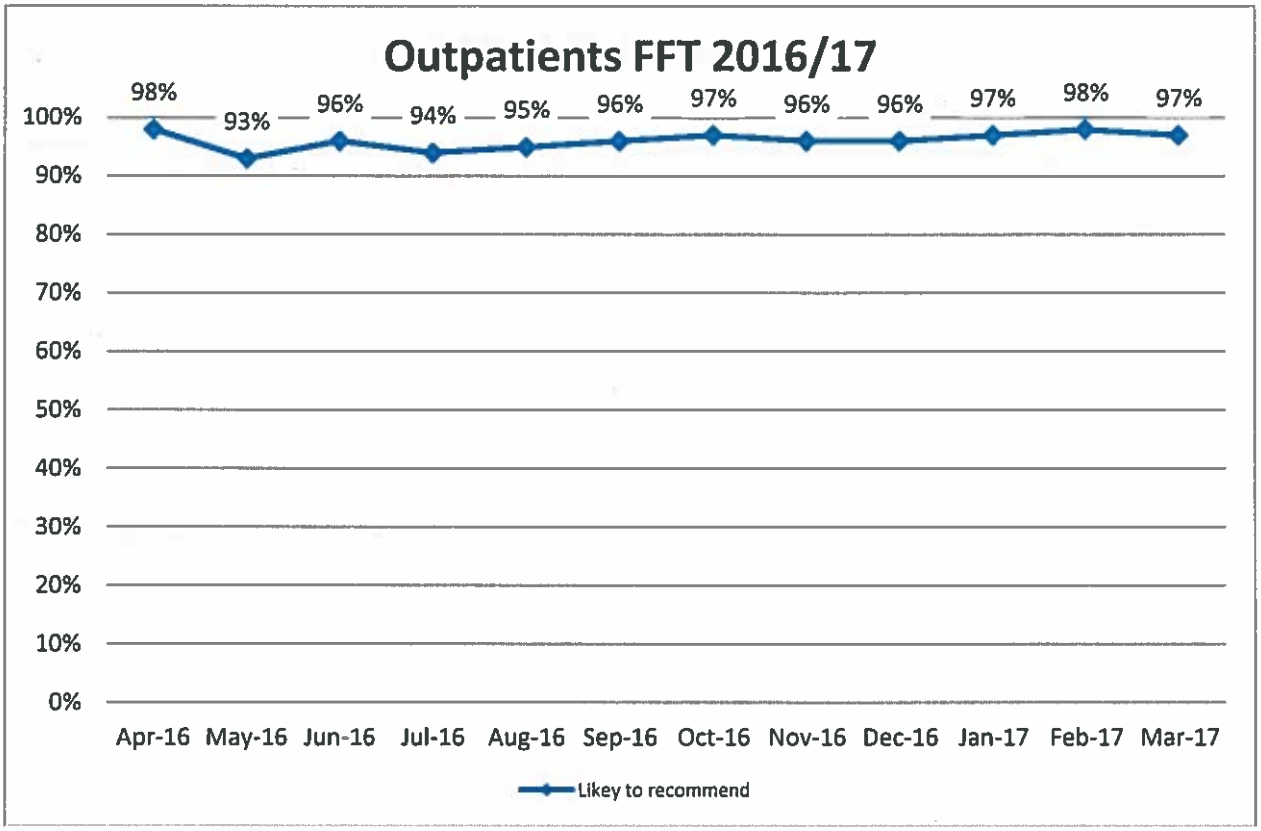
We continue to increase the patient feedback response rate through the use of iWantGreatCare and across the trust knowledge of its use is evident. The recent focus on maternity has shown the response rate increase from 0% in December to 13% in March, however, work will continue in this area to ensure an increase in the response rate is maintained. The Inpatient/Daycase increased month on month through quarter 4 and the Emergency Department maintained their response rate through the quarter.

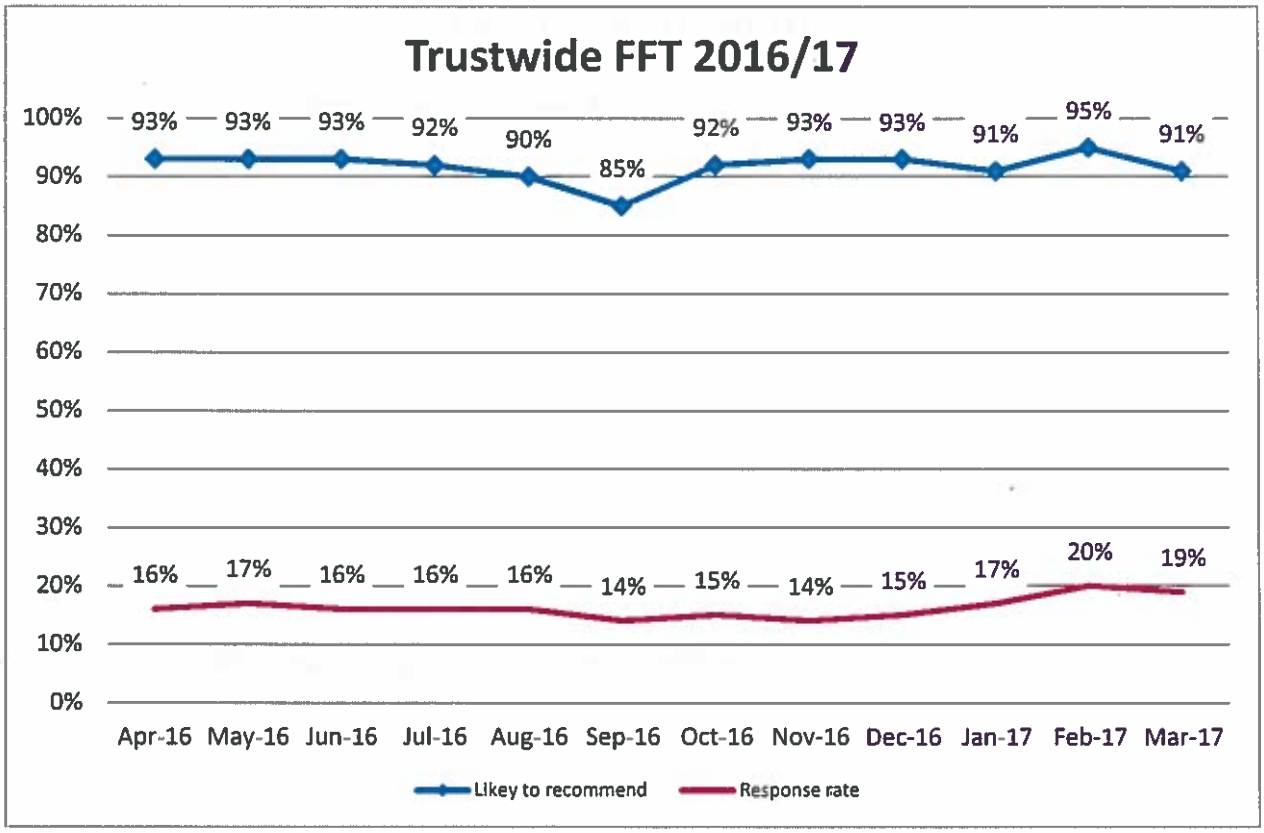
The following charts show the responses to the friends and family test for each area of submission (Emergency Department, Inpatient Wards, Maternity and Outpatient Clinics).



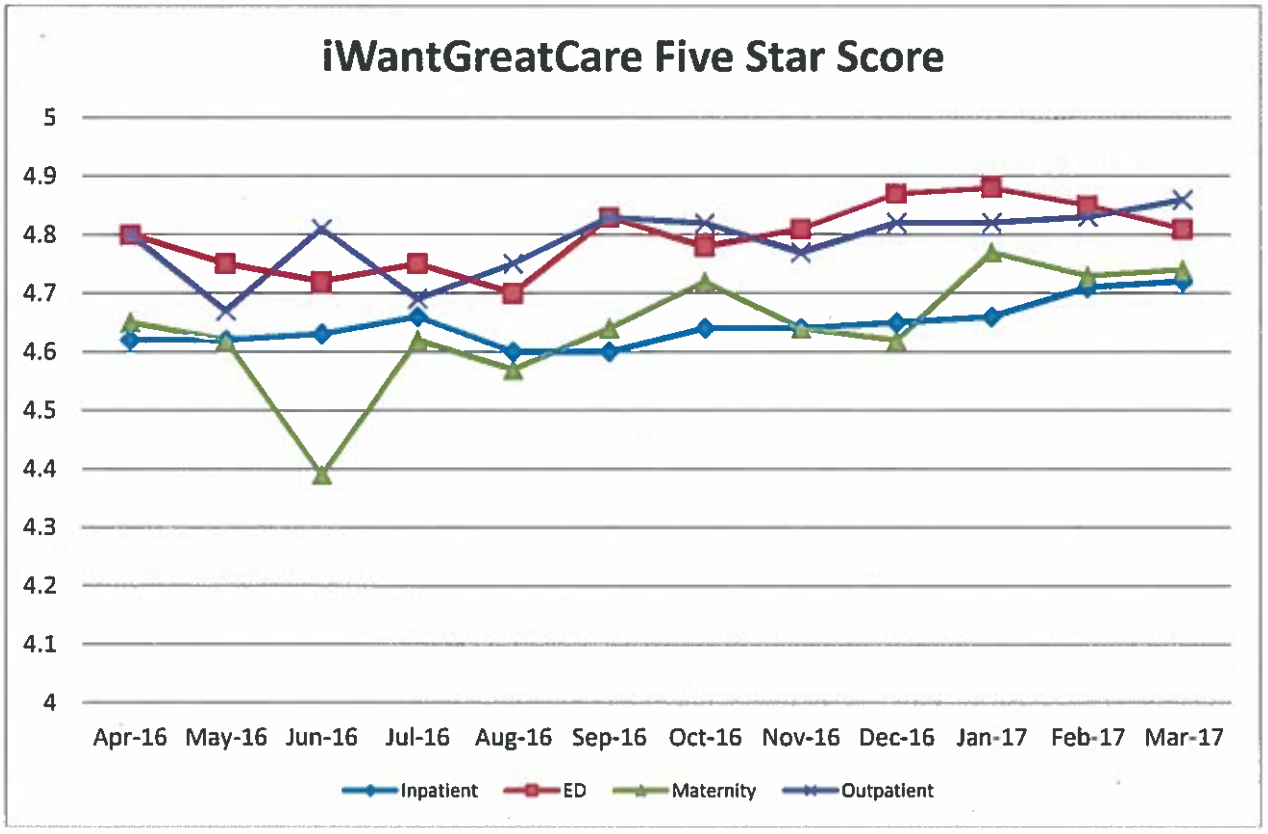

Inpatient FFT 2016/17
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
92% 93% 93% 93% 94% 90% 94% 93% 93% 91% 94% 94%
24% 24% 26% 30% 27% 25% 28% 22% 25% 27% 28% 29%
Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
Likey to recommend
Response rate
Response Rate Target


Maternity FFT 2016/17
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
96% 96% 94% 97% 68% 96% 94% 95% 96% 79% 95% 96%
17% 0% 0% 0% 1% 0% 0% 0% 0% 1% 3% 13%
Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17
Likey to recommend
Response rate
Response Rate Target


Outpatients FFT 2016/17
98%
93%
96%
94%
95%
96%
97%
96%
96%
97%
98%
97%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Likey to recommend


Trustwide FFT 2016/17
93%
93%
93%
92%
90%
85%
92%
93%
93%
91%
95%
91%
16%
17%
16%
16%
16%
14%
15%
14%
15%
17%
20%
19%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Likey to recommend
Response rate

The other questions included in the survey look at whether the patients felt they were treated with dignity and respect and felt involved enough in decisions made about their care, whether they receive 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.



3.5 Conclusion and Independent Auditor's Report to the Governors on the Quality Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF YEOVIL DISTRICT HOSPITAL FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Yeovil District Hospital Foundation Trust to perform an independent assurance engagement in respect of Yeovil District Hospital Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

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

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

Respective responsibilities of the directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2016/17* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.*

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 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 16 May 2017;
- feedback from governors, dated 12 May 2017;
- feedback from local Healthwatch organisations, dated 17 May 2017;
- feedback from Overview and Scrutiny Committee, dated 16 May 2017;

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated 18 January 2017;
- the latest national staff survey, dated 7 March 2017;
- Care Quality Commission Inspection, dated July 2016; and
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Yeovil District Hospital 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 2017, 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 Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the

measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

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

Basis for qualified conclusion on the percentage of incomplete pathways indicator

Our sample testing for the 'Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways for the year ended 31 March 2017' indicator identified eight instances where clock start or stop dates could not be corroborated back to supporting evidence. There was also a difference of 2,234 pathways between the submissions provided to the Department of Health and the data provided to KPMG.

Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the percentage of incomplete pathways indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

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

KPMG LLP

KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

30 May 2017

Annex 1 - Statement from the Council of Governors

The Council of Governors receives regular reports on all aspects of quality, including patient safety, clinical outcomes and patient experience. In addition governor observers are invited to attend the Governance Committee and the Quality Committee. Governors are also invited to attend the Board of Directors meeting on a rotation basis as well as welcomed to attend Part 1 Board of Directors throughout the year. These representatives are actively encouraged to participate and contribute their views, and they report back to the Council. 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 Yeovil District Hospital learns from the data collected and adapts policy accordingly.

During 2016/17, Yeovil District Hospital has succeeded in achieving performance targets and maintaining standards of care despite the extreme pressures on the NHS system both nationally and locally. The new AEC unit combined with the Symphony Complex Care Hub have helped to ease pressures on beds during the winter period.

The improvements in measures of patient safety and quality have largely been held. MRSA infection control improved in 2015/16. There was a third party assignment of one case of MRSA in November 2016, however as at 21 April 2017 the Trust had reached 739 days since it last reported a hospital required MRSA blood stream infection. The Trust continues to be significantly challenged by the reduced tolerance of no more than 8 cases for Clostridium difficile infection attributed to the Trust (those which occurred more than 72 hours after admission). Although the national target of 8 was not achieved, out of the 9 cases identified, only 2 were assessed as attributable due to identified lapses in hospital care. The remaining 3 have been provisional identified as no lapse in care but this will be confirmed shortly following a peer review with the CCG. The Council of Governors continues to receive regular reports on infection control and expects to see further improvement in the coming year.

The governors chose to change the Local Indicator from "Patient Experience of Discharge" to "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. A percentage of these were due to patients' self-discharge. The Council of Governors plan to keep the proportion of overnight discharges as a priority for 2017/18 and will monitor is accordingly.

The governors are encouraged by the progress with the Symphony programme, funded by NHS England in line with Yeovil District Hospital's Vanguard status. Integration of primary and secondary care is in progress with Symphony Healthcare Services and the complex care hubs are already improving care for patients with multiple conditions. The rehabilitation beds at Cooksons Court are also contributing significantly to further improve care for patients and the efficiency of the hospital.

Beyond its national Vanguard status Yeovil District Hospital continues to enjoy support from the local community, winning funding in several competitions, e.g. funding for the implementation of the "Hospital Companions" project.

The Council of Governors welcomes the continuing improvement shown by the results of the 2016 Staff Survey. The Trust received a response rate of 64%, which places the Trust as one of the highest response rate trust within the country. The results illustrated that the Trust

performs higher than average across many of the areas included in the survey. The Governors look forward to further improvement from the Trust's staff engagement programme.

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

Annex 2 - Statement from the Somerset Clinical Commissioning Group

NHS Somerset Clinical Commissioning Group (CCG) has reviewed the information provided by the Yeovil District Hospital NHS Foundation Trust. In so far as we have been able to check the factual details, our view is that the report is materially accurate. We can confirm that the Quality Account provides a balanced view of the Trusts achievements and as such is an accurate reflection of the quality of services provided.

Somerset CCG regularly review the quality and safety of the services provided by the Trust using a broad range of quality indicators and these are reported to the CCG at the Clinical Quality Review Meetings. These include the quality improvement priorities identified for 2016/17 as part of the Commissioning Quality and Innovation framework agreed with the Trust.

Quality Accounts are important to help Trusts improve public accountability for the quality of care they provide and an essential part of their development is the feedback from stakeholders. It is good to see this described this year with involvement of local people and service users about the priorities for 2017/18.

With the increased pressures on all NHS services during the year Yeovil Hospital has maintained the focus on quality and patient safety. The National Staff Survey has shown increasing staff who would recommend the Trust as a place to work. There are many challenges related to workforce and Trust is not alone, they have reported a high staff turnover, which may in part be related to staff retirement along with national issues with recruiting registered nurses, the Trust is currently recruiting nurse from as far away as India and Philippines.

In June 2016 the Care Quality Commission as the regulator of health care in the UK published the report of the inspection of the services at Yeovil District Hospital. The Trust was given an overall of 'Requires Improvement', a Quality Summit was held in July 2016. Key areas were identified for improvement, these included:

- the time taken to triage patients within the Emergency Department
- the nurse staffing levels in the Emergency Department
- mixed sex accommodation in the day surgery assessment unit, and
- concerns about the safety of children in the Children and Young People's Inpatient Unit due to the approach to admit young adults (18-24 years)

The Trust has committed to improvements identified by the CQC and is on track to achieve these.

The Maternity services have led significant change during the year, Yeovil District Hospital NHS Foundation Trust along with Taunton and Somerset Hospital NHS Foundation Trust has been accepted as a pilot site of new approaches to midwifery supervision. The six sites nationally will pioneer a new model of midwifery supervision in England ahead of legislative changes, which are due in spring 2017. The aim is to support midwives across all aspects of their role, leading to

improvements in maternity experiences and the quality of care in all parts of the health system. The Trust have also led along with Taunton and Somerset Hospital NHS Foundation Trust the Somerset bid to be an early adopter sites for Better Births, to support this transformational change in maternity services.

The Trust invites NHS Somerset Quality and Patient Safety Team to attend the Trusts Internal Quality Assurance Committee and welcomes the CCG to site visits for planned Assurance visits, Safety Thermometer days and Wards rounds. During the year we have had focused visited to the Emergency Department, Day Surgery Unit, Children's ward and outpatients.

PATIENT EXPERIENCE

The Trust is committed to developing strong patient feedback and uses national and local systems such as the NHS Choices, Friends and Family Test in conjunction with the Yeovil District Hospital NHS Foundation Trust iWantGreatCare feedback system. A challenge during the year has been the response rate to the Friends and Family test questions with low responses rate in Emergency Department, Outpatients and Maternity services. The Trust has tried to improve this by installing further highly visible collection points throughout the waiting area; this has shown to increase the responses.

Yeovil Hospital scored above the national average in the National Cancer Patient Experience Survey when patients were asked to rate their care out of ten, patients rated Yeovil Hospital 9.1 out of 10 on average, against the national average of 8.7 out of 10. The report showed patients felt they were able to discuss worries and fears they had during their hospital visits, they found it easy to contact their clinical nurse specialist when they needed to, and
they were involved as much as they wanted to be, in decisions about their care and treatment. The Trust is to be congratulated on this achievement.

The National Inpatient Surveys asks the views of adults who stayed the night at the hospital shows there has been improvements at the Trust that includes patients' perceptions of the quality of communication between medical professionals (doctors and nurses) and patients, the standards of hospital cleanliness and the availability of help to eat when needed. The results indicated that questions asking around patients being discharged from hospital and being involved in decisions have been less positive, Yeovil District
Hospital have been committed during the year to a focus on supporting patients and their family to be more involved in the planning of their discharge.

The results of the 2016 Patient Led Assessment of the Care Environment (PLACE) programme showed an improved performance in areas relating to food services, dementia environment and general cleanliness. The area of privacy and dignity and access in particular to single sex accommodation was rated below the national average for all Trusts.

A significant number of concerns were raised in the year due to car parking on site and part due to availability and part over the ticketing regime. The Trust new car park opened in March 2017 with 650 spaces and a pay-on-exit payment system.

PATIENT SAFETY

Yeovil District Hospital NHS Foundation Trust is an active member of the Somerset Infection Prevention Committee and has continued to demonstrate a collaborative approach in working with the CCG and local stakeholders to reduce incidence of hospital acquired infection for patients in Somerset. In 2016-17 the Trust did not achieve the national target set for the reduction of Clostridium difficile, nine cases were identified against a target of eight however only 2 cases were assessed as being attributed to the Trust as lapse of care. The Trust did achieve the challenging zero target for MRSA blood stream infections, one case was reported but this was attributed to a third party and not Yeovil Hospital.

The Trust benchmark nationally above the average rate of falls per 1,000 bed days and has continued to focus on reducing the numbers of patents who fall in hospital. The causes of falls in hospital patients can be complex and patients can be particularly vulnerable to falling due to medical conditions including delirium, side effects from medication or problems with strength or mobility. Whilst there has been significant reductions in the number of falls there is still an opportunity to improve performance further. The improvement work has included among other interventions a system called 'tag' care to ensure vulnerable patients remain visible to staff, if a staff member leaves the bay they pass care over to another staff member.

It is good to see that Yeovil District Hospital has appointed a Freedom to Speak up Guardian to support staff to feel safe to speak when things go wrong and to support the Trust ambition to have an honest open culture of shared learning.

CLINICAL EFFECTIVENESS

The Trust has changed reporting from Dr Foster to a new provider for the external mortality data review. From 1 April 2016 the Copelands Risk Adjusted Barometer (CRAB) will be used to provide outcomes data. The Trust has a Mortality review Group who monitor all hospital deaths and any outlier reports. The Trust is in the expected range for the Standardized Hospital Mortality Indicator (SHMI) which includes all deaths reported for patients who were admitted and either die while in hospital or within 30 days of discharge.

Yeovil has continued to lead the Symphony test and learn project, to develop joined up models of working and patient centred care. The project is making good progress in working with patients with long term conditions and supporting individuals to be cared for in their own home where possible.

Yeovil Hospital Healthcare

NHS

QUALITY IMPROVEMENT PRIORITIES FOR 2017/18

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

The CCG has worked with the Trust and partners to plan the Commissioning for Quality Innovations (CQUIN) in 2017-18 with a continued support to reducing the impact of serious infections and sepsis for patients, improving services for people with mental health needs who present in A&E and supporting proactive and safe discharge for all patients from hospital. The CQUINS in 2017/18 will be monitored across all hospitals sharing learning and quality improvements.

We look forward to continuing to work with Yeovil District Hospital NHS Foundation Trust during 2017/18 to improve the safety, clinical effectiveness and patient experience of the services provided by the Trust.

Please contact me at the above address if you wish to discuss any of the above comments further.

Yours sincerely

Sandra Corry
Director of Quality, Safety and Engagement

Copy: Deborah Rigby, Deputy Director of Quality, Safety and Engagement
Somerset Clinical Commissioning Group
Paul Goodwin, Deputy Managing Director and Director of Commissioning and Governance, Somerset Clinical Commissioning Group

Annex 3 - 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 Reporting Manual.

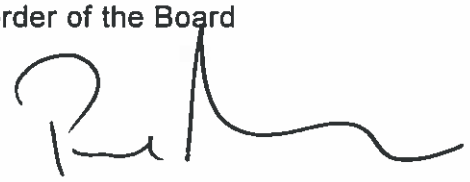
The content of the report is consistent with internal and external sources of information, including:

- Board minutes and papers between April 2016 and March 2017
- Papers relating to quality reported to the Board between April 2016 and March 2017
- Feedback from the Commissioners
- Feedback from the Governors
- 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 2016/17. 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 Monitor's annual reporting guidance (which incorporated 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



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Annex 4 - Statement from Healthwatch Somerset

healthwatch Somerset

Yeovil District Hospital NHS Foundation Trust Quality Account 2016-17

Introduction

Healthwatch welcomes the opportunity to comment on the draft Yeovil District Hospital NHS Foundation Trust Quality Account for 2016-17. Although Healthwatch Somerset has not been directly involved in the development of quality priorities this year, we note that topics were developed through consultation with staff, governors and patient representative groups. This included quarterly meetings with Healthwatch Somerset to review progress against the individual quality improvement priorities. As in previous years the priorities were based on the Trust's review of quality performance and the identification of areas for improvement.

Priority Areas

Our comments on the seven quality improvement priorities for 2017-18 are:

No preventable deaths

We support action by the Trust to reduce the number of preventable patient deaths whilst in hospital. No preventable deaths are measured by mortality ratios, serious incidents that resulted in deaths and mortality reviews. We note that the Trust has changed its external mortality alert system and now uses the Copelands Risk Adjusted Barometer (CRAB) to provide outcomes data. This has taken the place of the Dr Foster mortality alerts and as a result the Hospital Standardised Mortality Ratio (HSMR) data is no longer available for the Trust. However, we commend action taken to ensure that the outcome of any investigation, including actions to improve procedures, are shared with patients and their relatives.

Reduction in avoidable harm

We note that delivering a continuous reduction in avoidable harm is measured by processes such as Never Events, NHS Safety Thermometer, Sign up to Safety campaign measures, etc. We note with concern that there has been an increase in pressures ulcers from 75 in 2015-16 to 85 this year (although there has been an overall reduction over the last three years), and an increase in medication incidents from 820 in 2015-16 to 868 this year. Clearly, delivering avoidable harm must be a priority for the Trust. However, it is not clear what targets are being set for the future and how performance will be measured and published.

High reliability in clinical care

Achieving high reliability in clinical care is measured by compliance with a number of measures, such as acute kidney injury (AKI), sepsis, and pressure ulcer prevention. These are supported by

healthwatch Somerset

ward/board rounds to highlight patient safety issues, and support the improvement of quality and safety for patients. We know that achieving the right staffing levels is sometimes difficult, and we are aware that regular reports on staffing capacity and capability are discussed at Board meetings, but we would like to see more openness and transparency with the publication of individual ward staffing figures to provide some reassurance to patients and their families.

Deliver clinical services in line with National Seven Day Standards
We are unable to comment on this new quality improvement priority in the absence of any further information.

Engage with patients and their carers
We understand that this new quality improvement priority is to increase opportunities to engage with patients and their carers to understand what matters to them and plan with them accordingly. It is essential that patients and their carers are treated as equal partners, that their views are listened to, and they feel confident that they can influence their treatment.

Patients, carers and members of the public treated as equal partners
We fully agree with the view of the Trust that it is essential that patients, carers and members of the public are treated as equal partners and have confidence that their feedback is being listened to and has improved the delivery of services. But this should not be mere rhetoric - it is important that all Trust staff and clinicians make it clear how they have learnt from complaints and how services have improved as a result. In this context we note that the number of formal complaints made to the Trust has increased over the last three years, from 115 in 2014-15, 146 in 2015-16, to 153 this year. We also note the changes made to the Patient Experience Committee which should ensure that senior staff are involved in how to ensure a good experience for all patients and their relatives.

Implement digital technology to support effective care.
We commend the Trust's plans to continue to implement digital technology to support the delivery of timely and effective care.

Comment
We feel that some explanation is needed as to why there are two new priorities for 2017-2018, and why two have been dropped from last year. In particular why Reduction in MRSA and C-Diff, and Reduction in Patient Falls – two quality improvement priorities from last year – have been omitted. The C Diff target was 8, and the actual no of cases was 9 although we note that the Trust say that

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only 2 were attributed to "lapses in care". For falls, the number was 829 this year compared to 951 the previous year. Given that both these priorities continue to be of great concern to patients and the public we feel that some mention should be made as to why these two priorities have not been included in priorities for 2017-18.

Summary

Overall, we feel that this is a balanced and honest report covering both past performance (good and bad) and proposals for future achievements. And we look forward to exploring how links between the Trust and Somerset Healthwatch might be further developed over the next 12 months in order to strengthen public and patient involvement throughout the Trust.

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Informed voices & choices in health & social care

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Yeovil Hospital Healthcare

NHS

Consolidated Financial Statements For The Year to 31 March 2017

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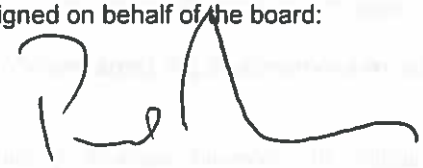
Statement of Directors' responsibilities in respect of the Accounts

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 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 information and to establish that the Trust's auditors is aware of that information.

Signed on behalf of the board:



Paul Mears, Chief Executive

Date: 26/5/17

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

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

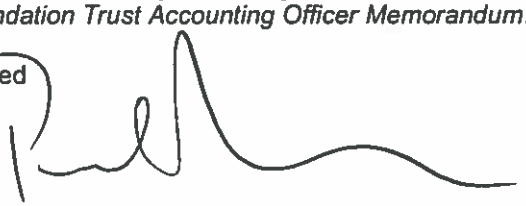
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Yeovil District Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts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

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of Yeovil District Hospital NHS Foundation Trust and to enable him to ensure that the accounts comply with the requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the Yeovil District Hospital NHS Foundation Trust and hence for taking any reasonable steps for the prevention and detection of fraud and other irregularities.

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 

Paul Mears, Chief Executive

Date: 26/5/17

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 (YDH), 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 YDH for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Following a previous advisory piece of work undertaken by the internal auditors (BDO) in 2015/16 to assess whether risk management culture is embedded across the Trust, a number of improvements have been implemented in 2016/17. These include:

- Standardising how risks are recorded, reviewed and monitored by the strategic business units at monthly clinical governance meetings to ensure consistency across the organisation.
- Ensuring that staff are clear as to their responsibilities with regard to risk management and further communicating the details of the risk management strategy amongst staff. The Risk Manager provides guidance and training for all new senior members of staff on the risk management processes at YDH and meets regularly with risk owners. In addition there is on-going training provided to management development programmes, principles of leadership training and nursing band 6 leadership programmes.
- The Risk Manager has worked with departments and service leads during 2016/17 and will continue to do so throughout 2017/18 to ensure all risks on the Trust's risk register, and identified risks managed locally within departments, are scored, actioned and reviewed appropriately.

During 2016/17, the internal auditors (BDO) undertook a further advisory piece of work (Maternity Risk Maturity) to assess whether a risk management culture is embedded throughout the maternity service. It identified a number of areas of good practice, including:

- The Department has a dedicated Risk Manager and Risk Management Strategy and Framework which provide the fundamentals and a framework for a sound system of risk management within a high risk area of the Trust.
- All staff joining the department are provided with an overview of risk management and their responsibilities within the risk management system during induction. Senior staff with a greater level of responsibility for risk management are provided with more in depth training sessions and complete risk management work books to evidence their understanding of risk management. Additionally the Trust Risk Manager is available where necessary to provide further guidance to any individuals who require it.
- The Maternity risk register is a standing agenda item at meetings of the Maternity Risk Management Committee which facilitates regular discussion of specific risks and their associated plans for mitigation.

- The Maternity Risk Management Committee facilitates regular review of the Department's approach to risk management and this, along with the review of the Maternity Risk Management Strategy and Framework, ensures that the Department's approach to risk management can be adapted in the light of new risk information.

A number of recommendations were made against each of the areas of the risk maturity assessment, however the key findings are noted below:

- A more proactive approach to identifying risks complementing the reactive approach currently used by the department. This should involve aligning service risks to the department's objectives, alongside any actions required to mitigate these risks.

- The Maternity Risk Management Strategy and Framework will be reviewed and updated to take account of all recent changes which have occurred within the department. The Maternity Risk Management Strategy and Framework will be incorporated within the Trust's Risk Management Strategy to ensure consistency across services and to align processes.

- A review exercise should be undertaken of the Maternity risk register due to the number of entries on the register which have not had any progress updates provided for periods in excess of a year. All entries should be reviewed to identify whether they are still appropriate to be included within the register and updated where changes are found to be required. A more in-depth review of the risk register should be undertaken on a regular basis by the Maternity Risk Manager to complement the high level review undertaken at Maternity Risk Management Committee meetings. This is to ensure that the register is maintained at a standard which facilitates effective risk management within the department. A new Maternity Risk Manager has been appointed to undertake this exercise.

These recommendations have been reviewed and it is intended that these will be implemented in 2017/18.

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

The Director of Nursing and Clinical Governance is the designated executive director with Board level accountably for clinical quality, safety and risk management. The Medical Director and Director of Strategic Development support this role. YDH has a designated Risk Manager within the clinical governance department.

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

Training

The Trust has an in-house programme of risk management training which is designed to equip staff with the necessary skills to enable them to manage risk effectively. The induction programme ensures that all new staff (clinical and non-clinical) are provided with details of internal risk management systems and processes which is augmented by local orientation. This includes the comprehensive induction of all junior doctors regarding key policies, standards and practice prior to commencement in clinical areas. Mandatory training reflects essential training needs and includes risk management processes such as fire, health and safety, manual handling, resuscitation, infection control, safeguarding and information governance. E-learning and workbooks support this programme. Skills and competencies are also assessed for medical device equipment and for blood transfusion to ensure safety in care.

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. Learning from incidents and claims is presented through the Patient Safety Steering Group whilst

complaints are reviewed through the Patient Experience Committee which continually identifies opportunities for improvement. This learning is cascaded via monthly peer review and governance meetings and quarterly at Trust-wide multi-professional learning events.

An advisory piece of work was also undertaken (Integrated Learning) to assess whether a learning culture is embedded throughout the Trust. The final audit report identified a number of areas of good practice, including:

- The Trust has implemented the Safeguard complaints and incident management system to record and monitor complaints and incidents. This system has built in stages to assist department in completing their investigations and to record any required actions. The system also allows for reports to be generated supporting the tracking of open complaints and incidents.

- Monitoring reports for complaints and incidents are produced and reviewed by management and the Board of Directors. Complaints are reported and reviewed by the new Patient Experience Working Group, and incidents are reported and reviewed by the Patient Safety Steering Group. Complaints and incidents are also reported to the Strategic Business Unit Boards, the Governance Assurance Committee and a summary is reported to the Board of Directors on a monthly basis.

As part of the review, BDO also raised some opportunities for improvement, which have been implemented within 2016/17 including:

- The complaints team should ensure that all responses from the investigating manager are detailed SMART actions, with allocated responsible offers and clear implementation dates. As such, from May 2016 responses to complaints include detailed actions, with allocated responsible offers and clear implementation dates from the investigating manager. Managers have also been provided guidance on developing SMART actions accompanied by a template action plan for completion. The complaints team actively review all responses and request further detail where there is insufficient information.

- All staff responsible for the completion of actions on incident forms have been reminded of their responsibilities to either document SMART actions on Safeguard or record that consideration has been taken of the incident with no actions required; this includes signing off of incidents in order that these are closed. Spot checks on department led investigations are undertaken to ensure that actions have been identified and that these are SMART. Templates have been amended to provide the definition and reminder of SMART actions; the email templates are also undergoing amendment to include these changes. Additional training on incident management documentation and management of reviews will be scheduled for all managers through the year.

- A key performance indicator dashboard has been developed for the recording, reviewing and completion of complaints and incidents. Quarterly reports from the Trust-wide Integrated Learning Forum will be presented to Governance Assurance Committee to highlight organisational, team and individual learning and to highlight departments shown to be failing to investigate and close complaints and incidents in a timely manner. The Forum meets on a monthly basis with terms of reference reflecting all national guidance on learning from deaths, incidents and complaints is expected in April 2017.

- The remit of the Patient Experience Team and management of the complaints and PALS process will be integrated with the Clinical Governance Department in 2017. The Department will be renamed Quality Governance Department.

YDH understands the importance of internal audits and uses these to ensure that processes in place throughout the Trust are robust and of a standard required. 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 2014/15 and approved by the Audit Committee. The strategy will be reviewed in 2017/18. The Risk Management Strategy clearly sets out the acceptable level of risk within the Trust. A risk appetite statement has been agreed by the Board and is clearly communicated within the Risk Management Strategy. The risk appetite statement identifies what level of risk is acceptable at departmental level, and at which point this needs 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.

Directors of the Strategic Business Units, supported by Associate Medical Directors and Associate Directors of Nursing, have overall responsibility for managing risk in their areas.
Risk registers are held for each of the Strategic Business Units and include all operational risks. Managers implement action plans and review the risks in line with the review dates set.

The Trust's Quality Improvement Strategy 2015-2018, which was reviewed and approved by the Board in 2015/16, is aimed at achieving excellence in clinical care. The Quality Report for 2016/17 sets out progress made in areas of patient safety, clinical outcomes and patient experience. Patient safety improvement work is monitored by the Patient Safety Steering Group which reviews and monitors data in the form of metrics. Information on quality and patient safety is received monthly by the Board and scrutinised in depth on a quarterly basis by the Governance Assurance Committee. Data quality is reviewed internally through Data Quality Steering Group, Information Governance Steering Group and through BDO as internal auditors who report to the Audit Committee.

Incident reporting forms part of the organisation's patient safety culture as does the importance of high level reporting, low level harm. Monitoring processes are in place to identify errors and risks and these are analysed for trends to prevent reoccurrence. Information is utilised from across the Trust from ward level to the Board. Where investigations are triggered, these are reviewed by the Clinical Governance team and the learning identified is reported back through clinical teams. Staff are encouraged to report incidents and support is provided by managers and through training. For example, junior doctors meet monthly to share their learning and experiences within a "no-blame" environment and undertake quality improvement projects which are presented to the Board at a seminar session.

YDH has mechanisms to report serious incidents through the national reporting and learning system (NRLS) and to act on safety alerts, recommendations and guidelines made by all relevant central bodies such as NHS England, the Medical Healthcare Regulatory Authority (MHRA) and the National Institute for Health and Care Excellence (NICE).

The Quality Committee has an annual work plan which assesses key areas in line with national standards. In doing so, it identifies areas of compliance risk and co-ordinates action plans for mitigation. Exception reports from the Quality Committee are presented to the Governance Assurance Committee. The Director of Nursing and Clinical Governance presents on any CQC regulatory updates as part of the monthly executive report to the Board. The impact and requirements of CQC regulation are reflected within internal procedural documents. The quality, operational, financial and workforce performance report presented each month to the Board is categorised under the CQC standards. The Foundation Trust is fully compliant with the registration requirements of the CQC.

The Trust was subject to a CQC comprehensive inspection in March 2016 with the final report published in July 2016. The Trust was given an overall rating of Requires Improvement and a summary of the findings and actions taken are outlined in the Annual Quality Account.

A team of 40 inspectors assessed each of the 8 Core Services, Urgent and Emergency services, Medical care (including older people's care), Critical Care, Maternity and Gynaecology, Surgery, Services for Children and Young People, End of life care and Outpatients and Diagnostic Imaging.

The inspection team spoke to staff, governors, patients and their carers, in addition to holding a public forum for feedback and also receiving feedback from our key partners. A number of focus groups were conducted, where specific staff groups had the opportunity to share any thoughts about the Trust and the services it provides, and interviews were held with the Chief Executive and Directors, Clinical Leads and Specialist Nursing and Medical Staff.

The inspection team were required to assess our Services and our Organisation against the 5 Key Domains:

- Safe
- Effective
- Caring
- Responsive
- Well-Led

The following ratings were achieved:

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

A comprehensive action plan was developed as result of the report and this has further informed the Trust's Quality Priorities. This action plan is subject to review and monitoring via the Governance Assurance Committee to ensure progress is evident. A further inspection, using the CQC modified inspection process, is anticipated in 2017/18.

The Care Quality Commission did not take enforcement action against YDH during 2016/17.

Nationally, the NHS is facing unprecedented levels of demand which have been reflected at YDH. The Trust's primary district of South Somerset has a much higher proportion of residents aged over 65 (21.6%) than the rest of England (16.3%). This proportion is forecast to increase; estimates suggest that by 2030 there will have been a 43% increase in those aged over 55, compared to a static working population. Within this increase, the number of people aged over 85 is forecast to increase by 120%. YDH also delivers services to a proportion of residents in North and West Dorset and parts of Mendip where the challenges are broadly similar.

The consequences of this are well known – ever increasing demand on health and social care coupled with a static working age population, and difficulties in recruiting sufficient staff to deal with the increasing demand and the complexity of patient conditions. This pressure is felt across the local health and social care economy; however

with new models of care introduced at YDH, the Trust has opposed the trend achieving national performance targets in the latter half of the year along with an improvement in its underlying deficit position and achievement of the control total set by NHS Improvement. Despite this, the Trust still faces a number of risks linked to this. Broadly, these are:

- Overcrowding in the emergency department in times of high demand;
- Increased demand resulting in escalation, cancellation of elective activity and risks to quality of care (including falls, pressure ulcers, medication errors and staff sickness);
- Challenges in maintaining safe staffing and safe services in times of escalation;
- Medical patients being nursed in non-medical environments, lack of medical support and lack of medical skills in workforce;
- The risk associated with the delivery of RTT standards, resulting from the cancellation of elective surgery; and
- Increased agency utilisation and expenditure.

YDH has action plans in place to mitigate these risks, including an ongoing medical and nursing recruitment campaign, the creation of Symphony Complex Care Teams to provide a better way of supporting people living with three or more specific long-term conditions, the addition of reablement beds at Cooksons Court with the aim to getting patients home and the creation of new models of care including the delivery of systemised surgery through the formation of Daycase UK.

During 2016/17 the Trust also invested in a number of schemes that the Board considered vital in ensuring it maintained the quality of care provided to its patients. These included:

- Meeting safer staffing levels;
- Tag Care, a system of mitigating the risk of falls in a defined cohort of patients;
- Increasing junior medical cover and out of hours support services;
- Increasing midwifery staffing levels;
- Focusing on infection prevention and control; and
- Appointment of the Freedom to Speak Up Guardian and Guardian of Safe Working.

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

In the long-term, and given the strategic nature of the challenges, YDH has been progressing work with primary care and local partners on the development of radical new models of integrated care, which will deliver a sustainable, high quality health and social care system. Significant progress has been made; key highlights of which are:

- The establishment of Symphony Healthcare Services which has seen the integration of four GP practices to date, with another eight undergoing the due diligence process, two of whom are anticipated to be integrate within the coming months.
- Roll out of the new complex care and enhanced primary care models with over 3,600 patients having been touched by one of these models. Evidence suggests that this is starting to have a tangible impact on acute demand as evidenced by new Symphony operational dashboards.
-

- The establishment of Daycase UK, a joint venture between YDH and Ambulatory Surgery International (a major international provider of daycase surgery) to take forward our vision of developing a new model of 'systematised' surgery. Work has commenced to deliver efficiencies within the existing day surgery footprint.

- The development of a number of innovative partnerships with commercial organisations which are helping the Trust to realise its strategic ambitions.

- Commitment by Somerset CCG to issue an outcome based contract for South Somerset in 2017/18 which supports our journey to become an Accountable Care Organisation (ACO).

- Key enhancements to the Trust's physical infrastructure, including the development of a new multi-storey car park which opened in March 2017.

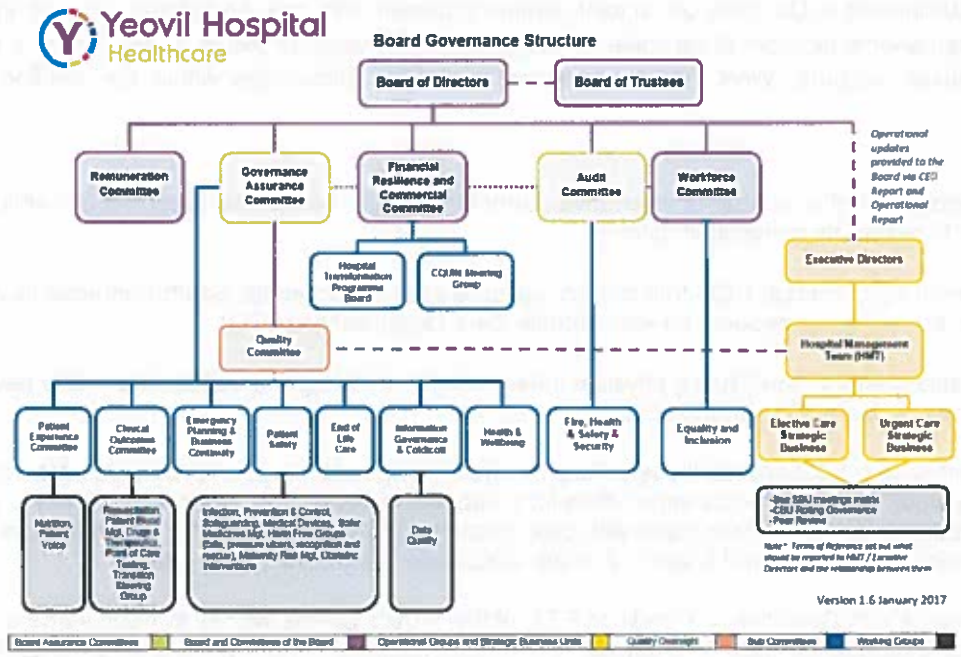
The Board is satisfied that YDH applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS. The Trust has structured governance arrangements in place with clear lines of reporting from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

To ensure compliance with Condition 4 (Condition FT4) of the Trust's license with NHS Improvement, which relates to governance, NHS foundation trusts are subject to the recommendations of the NHS Foundation Trust Code of Governance (modelled on best practice UK governance principles) and the Well-Led Framework for Governance Reviews, which encourage Boards to conduct a formal evaluation of their own performance and that of its committees and directors. Accordingly, and as reported last year, during 2013/14, Ernst & Young LLP was commissioned to undertake a review of the performance and effectiveness of the Trust's Board and its committees. The recommendations were presented to the Board in March 2014. The overall findings were positive in acknowledging the Board and its committees were functioning well, although they identified some opportunities for improvement. An action plan containing the key recommendations was implemented in 2014/15 and into 2015/16.

The Trust has also implemented a number of amendments to previous processes, including the clarification of the roles, responsibilities and reporting structures of the Board alongside a review and revision of their terms of reference. A rolling agenda programme for the Board and its committees has been created, accompanied by a development programme for the Board shaped through Board seminar sessions and Board monthly developmental away days.

Following previous reviews of the governance structure by the internal auditors, a revised governance structure was approved which streamlined and clarified the roles of the various committees and groups, various committees (such as Financial Resilience Committee and Commercial Committee) were merged to create overarching integrated governance committees which report directly to the Board. A Quality Committee was established where quality issues and the CQC standards of care are reviewed. In 2015/16, a Workforce Committee was established to meet on a monthly basis to advise the Board on the strategic, transformational workforce agenda and to review the monthly HR data sent to the Board. The committee focuses on agency staffing rates and expenditure, mandatory training, appraisal, occupational health, sickness management (including long term) and ESR data quality.

During 2016/17, the Board approved a revised governance structure in June 2016 and January 2017 following the creation of the Hospital Transformation Board (a group designed to help mitigate any risks to delivery of the Trust's strategic objectives as set out in the Board Assurance Framework) and the changes to the Patient Experience Strategy Group and the addition of the Transition Steering Group which reports directly to the Clinical Outcomes Committee. The Trust's current Board Governance Structure is show below:



YDH has been selected to be one of the pilot sites for the joint NHS Improvement and Care Quality Commission's inspections of the well-led domain as well as the use of resources. This review will be undertaken in June 2017 and the results will be presented to the Board following this.

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 assurance committees and the Financial Resilience and Commercial Committee, Workforce Committee and Quality Committee.

The Board Assurance Framework is reviewed by the Strategy and Performance Working Group of the Council of Governors (as well as the Audit Committee and the Board). During 2016/17, YDH held its annual general meeting along with the opportunity for members of the public to interact with staff from various departments and to provide feedback.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

YDH 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.

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

As outlined earlier in the annual governance statement, ever increasing demand on health and social care, coupled with a static working age population and difficulties in recruiting sufficient substantive staff to deal with the increasing demand and the complexity of patient conditions has resulted in a challenged economic environment across the NHS. This has been compounded recently by a significant increase in the number of delayed transfers of care. While YDH has a history of excellent performance and sound financial management, the existing,

traditional models of care and incentives have continued to contribute to the Trust's deficit position in 2016/17. During late 2014 and early 2015, YDH undertook a deficit diagnostic with the support of Oliver Wyman Consultancy. The Financial Recovery Plan (FRP) that resulted was shared with NHSI as part of their investigation into the Trust's financial position; an investigation which resulted in no formal enforcement action and which recognised that YDH has the right plans and leadership in place to deliver long-term sustainability for the organisation through the creation of new models of integrated care, which has been recognised nationally with the award of Vanguard status, facilitating access to transformation funding to implement new models of care that will improve the service received by patients, whilst also delivering a sustainable financial position. In the short-term, and as a consequence of the planned deficit budget in 2017/18, the Trust will require short term financial support in the way of loans from the Department of Health.

To ensure ongoing monitoring and scrutiny, operational and strategic plans are reviewed by the Board and by the governor Strategy and Performance Working Group. Budget setting each year involves detailed analysis by qualified accountants within the finance team using current year actuals as a baseline. The team then works with departments and managers to review their proposed budgets, making amendments based on their input as required. The executive directors consider the draft budget in its entirety prior to non-executive and Board challenge, including thorough consideration by the Financial Resilience and Commercial Committee. This robust process ensures that resources are planned on an economic, efficient and effective basis.

Overall performance is monitored via the quality, operational and financial performance overview at monthly meetings of the Board. Operational management and the co-ordination of services are delivered by the strategic business units which comprise executive directors, associate medical directors and associate directors of nursing. Performance was reviewed weekly by the Hospital Management Team in 2016 and bi-weekly in 2017. 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.

During 2016/17, following two years of planning and preparation, the Trust implemented phase one of TrakCare, its electronic patient record system as part of the SmartCare project. TrakCare provides for safer and better coordinated care through one united healthcare information system allowing a complete view of the patient's journey and is the first major step toward becoming paperless. The second phase due to go live in 2017/18 will allow the hospital to realise the real benefits of become a paperless hospital, with enhanced clinical functionality, electronic notes and electronic prescribing.

Information Governance

There were two Level 2 information governance breaches in 2016/17 that required external reporting in line with the information governance incident reporting tool. The Information Commissioner's Office (ICO) investigated the two separate incidents and decided in both cases no further action was necessary.

The first incident involved the inclusion of three appointment letters within one envelope therefore some patients received their own appointment letter along with two other letters. The ICO provided recommendations in relations to the incident; this included a review of the Trust's policies and procedures for handling data and a review of the Trust's approach to staff training. These recommendations have been actioned to ensure that this incident does not happen in the future.

The second incident concerned the carbon copying of patients via email within a cohort of patients. The ICO provided recommendations to be implemented following which the Trust has provided further training to members of staff group concerned. The decision has also been taken that this type of mass communication would be undertaken by the communications team to ensure that this incident does not occur again.

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

The Senior Information Risk Owner is the Chief Financial and Commercial Officer. The Information Governance toolkit remains an essential tool in monitoring progress against national standards and assessment of information security is undertaken annually as part of this process.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual. To provide assurance that the quality report presents a balanced view, the following arrangements are in place:

- Information in relation to quality, safety and patient experience is considered by the relevant sub-groups and the strategic business units. Data is presented to the Board on a monthly basis and scrutinised by the Governance Assurance Committee (which is chaired by a non-executive director) on a quarterly basis.
- Operational and executive leads present to the Governance Assurance Committee to enable the opportunity for debate about quality measures and any key risks.
- Data quality is analysed monthly by the clinical governance and information teams.
- The Patient Safety, Patient Experience and Clinical Outcomes Committees monitor safety incidents, complaints, mortality and clinical audit reports and the data presented to review progress against the quality strategy and to produce the Quality Report.
- The Associate Director of Patient Safety and Quality leads quality improvement work jointly with the Clinical Director for Patient Safety and members of the Patient Safety Team.
- Compliance with NICE guidance is measured and monitored through the Clinical Business Units and the Clinical Outcomes 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 and Hospital Transformation Board.
- The Quality Report in draft form is externally reviewed by the Somerset Clinical Commissioning Group, HealthWatch, the Somerset Overview and Scrutiny Committee.
- The local indicator for the Quality Accounts is selected by the Council of Governors and monitored by them on a quarterly basis alongside quality and patient safety updates from the Director of Nursing.
- Assurance is gained through the annual internal audit programme and by the work of the external auditors in reviewing the quality report indicators.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical governance and the executive managers and clinical leads within YDH 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 Assurance Committee and Quality Committee; a plan to address weaknesses and ensure continuous improvement of the system is in place.

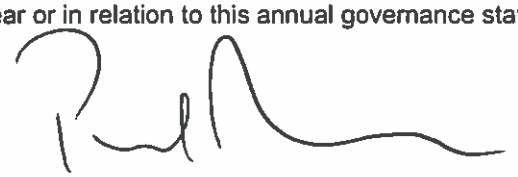
The process for maintaining the effectiveness of the system of internal control is in accordance with the risk management strategy. Assurance as to the effectiveness of the system of internal control is primarily overseen by the Audit Committee, which reports to the Board, supported by the Governance Assurance Committee. Where weaknesses are identified, recommendations are made and action plans for improvement monitored through this assurance process to ensure continuous improvement of the system in place. The assurance committees also

review the Quality Committee work plan and governance framework in respect of their assigned risk review areas, reporting directly to the Board.

The 2016/17 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 YDH. 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.



Paul Mears, Chief Executive

26/5/17

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

KPMG

Independent auditor's report

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

Opinions and conclusions arising from our audit

1. Our opinion on the financial statements is unmodified

We have audited the financial statements of Yeovil District Hospital NHS Foundation Trust for the year ended 31 March 2017 set out on pages 21 to 60. In our opinion:

- the financial statements give a true and fair view of the state of the Group and the Trust's and the Group's affairs as at 31 March 2017 and of the Trust and the Group'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 Department of Health's Group Accounting Manual 2016/17.

Overview		
Materiality: Group financial statements as a whole	2.0% of total income from operations	£2.9m
Materiality: Trust financial statements	1.9% of total income from operations	£2.6m

Risks of material misstatement		vs 2015/16
Recurring risks	Valuation of land and buildings	◀▶
	Recognition of NHS and non-NHS income	◀▶

Key

◀▶ Risk level unchanged from prior year

2. Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements, the risks of material misstatement that had the greatest effect on our audit, in decreasing order of audit significance, were as follows:

	The risk	Our response
Land and Buildings Land £4.3m; (2015/16: £4.7m) Buildings: £45.6m; (2015/16: £37.1m) *Refer to page 20 (Audit Committee Report), page 29 (accounting policy) and page 47 (financial disclosures).*	**Valuation of land and buildings:** Land and buildings are required to be held at fair value. The Groups main land and buildings relate to the hospital site and the associated land. Land and buildings are initially recognised at cost, but subsequently are recognised at current value in existing use (EUV). For non-specialised property assets in operational use EUV is market value in existing use. Specialised assets where no market value is readily ascertainable, are recognised at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property. An interim review is carried out each year to test assets for potential impairment and a full valuation is carried out every five years. There is significant judgment involved in determining the appropriate for each asset according to its degree of specialisation, as well as over the assumptions made in arriving at the valuation of the asset. In particular the DRC basis of valuation requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site. The valuation is carried out by Gerald Eve, 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 desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. The Group had a full valuation at 31 March 2015, and desktop valuation undertaken at 31 March 2017 resulting in a £0.6m increase in the value of the land and buildings balance.	Our procedures included: — **Assessment of the external valuer:** We assessed the competence, capability, objectivity and independence of the valuer and the overall methodology of the valuation to identify whether the approach was in line with industry practice and the valuer was appropriately experienced and qualified. We used our own specialist to verify the methodology and assess the conclusions in the final report — **Agreement of underlying asset records:** We compared the accuracy of the base data provided to the valuer against the Trust's Property Register. — **Consideration of valuation assumptions:** We critically assessed the assumptions used in preparing the valuation by considering them against Gerald Eve indices and industry norms. — **Impairment review:** We considered how the Group and the valuer had assessed the need for an impairment across its asset base either due to a loss of value or reductions in future service potential. — **Additions to assets:** For a sample of assets added during the year we agreed the cost of the additions to invoice and confirmed that an appropriate valuation basis had been adopted when they became operational and that the Group would benefit from future service potential. — **Consideration of disclosures:** We considered the adequacy of the disclosures around the key judgements and degree of estimation involved in concluding that there has been no material movement, other than those arising from the desktop valuation, in the value of land and buildings since 31 March 2016.

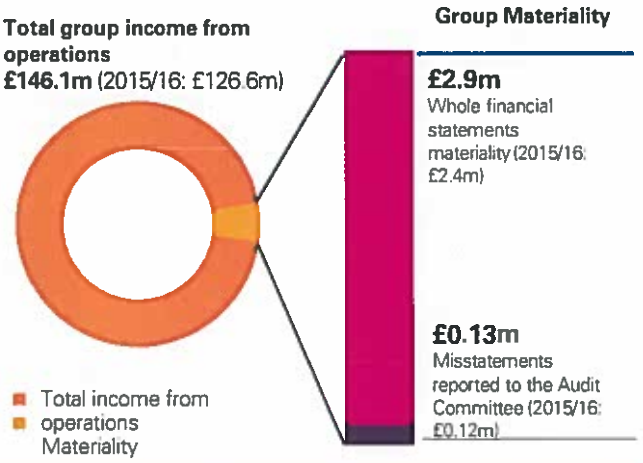
	The risk	Our response
NHS and non-NHS income Income: £146.1m (2015/16: £126.6m). Operating income from patient care activities £115.6m (2015/16 £106.4). Other Operating Income £30.5m (2015/16 £20.2m). *Refer to page 20 (Audit Committee Report), page 37 (accounting policy) and page 39 (financial disclosures).*	**Recognition of NHS and non-NHS income:** Of the Group's reported total income, £115.6m (2015/16, £106.4m) came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). Income from CCGs and NHS England make up 79% of the Group's income. The majority of this income is contracted on an annual basis, but actual income is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then commissioners are able to impose fines, reducing the level of income generated. In 2016/17, the Group received transformation funding from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Group was allocated £4.4m of transformation funding, and also received £0.9m of additional bonus funding. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £250,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. The Group reported total income of £30.5m (2015/16: £20.2m) from other activities, principally Education or Research. Much of this income is generated by contracts with other NHS and non-NHS bodies which are based on varied payment terms, including payment on delivery, milestone payments and periodic payments.	Our procedures included: — **Contract agreement:** We agreed 94% of commissioner income to the signed contracts and selected a sample of the largest balances (comprising 92% of income from patient care activities) to agree that they had been invoiced in line with the contract agreements and payment had been received. — **Agreement of contract variations**: We agreed that the levels of over and under performance reported were consistent with contract variations and challenged the Group's assessment of the level of income where these were not in place by considering our own expectation of the income based on our knowledge of the client and experience of the industry. — **Income cut-off**: We carried out testing of invoices for material income from NHS organisations, and other income, in the month prior to and following 31 March 2017 to determine whether income was recognised in the correct accounting period, in accordance with the amounts billed to corresponding parties. — **Agreement of balances:** We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers and compared the values they are disclosing within their financial statements to the value of income captured in the financial statements. We sought explanations for all variances over £0.25m, and all balances in dispute over £0.25m, and challenged the Group's assessment of the level of income they were entitled to and the receipts that could be collected. — **Sustainability and Transformation income:** We agreed the transformation funding due at the year end to the confirmation received from NHSI and agreed that this was appropriately recorded within the financial statements; — **Other income:** We tested material other income balances by agreeing a sample of income transactions through to supporting documentation and bank statements.

3. Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements of the Group was set at £2.9m (2015/16: £2.4m), determined with reference to a benchmark of actual income from operations (of which it represents approximately 2%).

The materiality for the financial statements of the Trust was set at £2.6m (2015/16: £2.4m), determined with reference to a benchmark of forecast income from operations (of which it represents approximately 2%).

We consider income from operations to be more stable than a surplus-related benchmark. We are not aware of any significant unusual transactions that require us to normalise the benchmark. We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.13m (2015/16: £0.12m), in addition to other identified misstatements that warrant reporting on qualitative grounds.



4. Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5. We have nothing to report in respect of the matters on which we are required to report by exception

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and financial statements taken as a whole is fair, balanced and understandable; or
- the Audit Committee's commentary on page 4 of the Annual Report does not appropriately address matters communicated by us to the Audit Committee.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.
- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required 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 respect of the above responsibilities.

6. We have completed our audit

We certify that we have completed the audit of the accounts of Yeovil District Hospitals 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.

Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities on page 2 the accounting officer is responsible for the preparation of financial statements that give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors. A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its 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, as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

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. 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 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.

Rees Batley

Rees Batley
for and on behalf of KPMG LLP
Chartered Accountants and Statutory Auditor
66 Queen Square, Bristol, BS1 4BE

30 May 2017

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2017 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:

Paul Mears – Chief Executive

Date 26/5/17

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2017

	Note	Group 2016/17 £'000	Group 2015/16 £'000	Trust 2016/17 £'000	Trust 2015/16 £'000
Operating income from patient care activities	3	**115,652**	106,455	**111,871**	106,455
Other operating income	4	**29,546**	20,216	**25,510**	19,736
Total operating income		**145,198**	126,671	**137,381**	126,191
Operating expenses	5	**(156,720)**	(143,985)	**(152,231)**	(143,347)
Operating Deficit		**(11,522)**	(17,314)	**(14,850)**	(17,156)
Finance income	9	**31**	30	**19**	27
Finance expenses	9	**(885)**	(185)	**(799)**	(185)
PDC dividends payable		**(309)**	(864)	**(309)**	(864)
Net finance costs		**(1,163)**	(1,019)	**(1,089)**	(1,022)
(Losses) on disposal of non-current assets	10	**0**	(427)	**0**	(427)
Share of profit of associates/joint arrangements		**991**	0	**950**	**0**
Deficit for the year		**(11,694)**	(18,760)	**(14,039)**	(18,605)
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	11	**(608)**	0	**(608)**	0
Revaluations	15	**2,044**	0	**2,044**	0
Total comprehensive expense for the period		**(10,258)**	(18,760)	**(12,603)**	(18,605)
Deficit for the period attributable to:					
non-controlling interests; and		**(102)**	0	**0**	0
the Foundation Trust		**(11,592)**	(18,760)	**(14,039)**	(18,605)
Total comprehensive expense for the period attributable to:					
non-controlling interests; and		**(102)**	0	**0**	0
the Foundation Trust		**(10,156)**	(18,760)	**(12,603)**	(18,605)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2017

	Note	Group 31 March 2017 £'000	Group 31 March 2016 £'000	Trust 31 March 2017 £'000	Trust 31 March 2016 £'000
Non current assets					
Intangible assets	14	**4,333**	3,347	**4,333**	3,347
Property, plant and equipment	15	**57,290**	54,525	**55,512**	54,525
Investments in associates and joint ventures		**41**	0	**144**	0
Trade and other receivables	17	**400**	565	**400**	565
Total non current assets		**62,064**	58,437	**60,389**	58,437
Current assets					
Inventories	16	**2,027**	2,102	**2,017**	2,102
Trade and other receivables	17	**8,830**	5,138	**8,347**	5,006
Cash and cash equivalents	18	**5,426**	5,168	**1,200**	4,654
Total current assets		**16,283**	12,408	**11,564**	11,762
Current liabilities					
Trade and other payables	20	**(15,178)**	(17,977)	**(14,541)**	(17,817)
Borrowings	22	**(18,461)**	(138)	**(18,419)**	(138)
Provisions	21	**(129)**	(114)	**(129)**	(114)
Total current liabilities		**(33,768)**	(18,229)	**(33,089)**	(18,069)
Total assets less current liabilities		**44,579**	52,616	**38,864**	52,130
Non current liabilities					
Trade and other payables	20	**(312)**	0	**0**	0
Borrowings	22	**(26,308)**	(24,555)	**(24,857)**	(24,555)
Provisions	21	**(1,115)**	(999)	**(1,033)**	(999)
Total non current liabilities		**(27,735)**	(25,554)	**(25,890)**	(25,554)
Total assets employed		**16,844**	27,061	**12,974**	26,576
Financed by					
Financed by					
Public dividend capital	25	**41,864**	41,823	**41,864**	41,823
Revaluation reserve		**9,402**	7,978	**9,402**	7,978
Income and expenditure reserve		**(37,848)**	(23,225)	**(38,292)**	(23,225)
Non-controlling interest		**(102)**	0	**0**	0
Charitable fund reserves		**3,528**	485	**0**	0
Total taxpayers' & others' equity		**16,844**	27,061	**12,974**	26,576

The notes on pages 26 – 60 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:

Paul Mears – Chief Executive
Date 26/5/17

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 2016/2017

Group	Total	Charitable Funds	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Non - Controlling Interest
	£'000	£'000	£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2016	27,061	485	41,823	7,978	(23,225)	0
Deficit for the year	(11,694)	3,057	0	0	(14,649)	(102)
Revaluation gains/(losses) and impairment losses property, plant and equipment	1,436	0	0	1,436	0	0
Transfer to the income and expenditure account in respect of assets disposed of	0	0	0	(12)	12	0
Share of comprehensive income from associates and joint ventures	0	0	0	0	0	0
Public Dividend Capital received	41	0	41	0	0	0
Other transfers between reserves	0	0	0	0	0	0
Movements on other reserves	0	(14)	0	0	14	0
Total comprehensive income for the year	(10,217)	3,043	41	1,424	(14,623)	(102)
Taxpayers' Equity at 31 March 2017	**16,844**	**3,528**	**41,864**	**9,402**	**(37,848)**	**(102)**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 2015/2016

	Total	Charitable Funds	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£'000	£'000	£'000	£'000	£'000
Taxpayers' Equity at 1 April 2015	45,821	640	41,823	7,998	(4,640)
Deficit for the year	(18,760)	(141)	0	0	(18,619)
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	0	0	0
Transfer to retained earnings on disposal of assets	0	0	0	(20)	20
Public Dividend Capital received	0	0	0	0	0
Movements on other reserves	0	(14)	0	0	14
Total Comprehensive income for the year	(18,760)	(155)	0	(20)	(18,585)
Taxpayers' Equity at 31 March 2016	**27,061**	**485**	**41,823**	**7,978**	**(23,225)**

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 2017

	Note	Group 2016/17 £'000	Group 2015/16 £'000	Trust 2016/17 £'000	Trust 2015/16 £'000
Cash flows from operating activities					
Operating deficit		**(11,522)**	(17,314)	**(14,850)**	(17,157)
Non-cash income and expense:					
Depreciation and amortisation		**4,044**	3,612	**4,038**	3,612
Net impairments and reversals of impairments		**788**	0	**788**	0
Income recognised in respect of capital donations		**(780)**	0	**(780)**	0
(Increase)/decrease in receivables and other assets		**(3,685)**	(284)	**(3,212)**	(436)
(Increase)/decrease in inventories		**75**	34	**75**	34
Increase/(decrease) in payables and other liabilities		**(1,440)**	3,876	**(1,901)**	3,871
Increase/(decrease) in provisions		**120**	(43)	**38**	(43)
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		**449**	0	**0**	0
Other movements in operating cashflows		**950**	157	**950**	0
Net cash generated from operations		**(11,001)**	(9,962)	(14,854)	(10,119)
Cash flows from investing activities					
Interest received	9	**19**	27	**19**	27
Payments to acquire intangible assets	14	**(1,603)**	(1,826)	**(1,603)**	(1,826)
Payments to acquire tangible fixed assets	15	**(6,971)**	(7,235)	**(5,325)**	(7,077)
Sale of property,plant and equipment	15	**52**	0	**52**	0
Receipt of cash donatios to purchase capital assets		**780**	0	**780**	0
Net cash used in investing activities		**(7,723)**	(9,034)	**(6,077)**	(8,876)
Cash flows from financing activities					
Public Dividend Capital received	25	**41**	0	**41**	0
Loans received from Department of Health	22	**18,745**	23,000	**18,745**	23,000
Movements on other loans		**1,493**	0	**0**	0
Interest paid on loans		**(750)**	(79)	**(750)**	(79)
Loans repaid - including finance lease capital		**(155)**	(155)	**(155)**	(155)
Interest element of finance lease		**(68)**	(69)	**(68)**	(69)
Other capital movements		**(64)**	(196)	**(64)**	(196)
PDC dividends paid		**(272)**	(905)	**(272)**	(905)
Charitable fund financing activities		**12**	3	**0**	0
Net cash used in financing activities		**18,982**	21,599	**17,477**	21,596
Increase / (decrease) in cash and cash equivalents		**258**	2,603	**(3,454)**	2,603
Cash and cash equivalents at 1 April		**5,168**	2,565	**4,654**	2,051
Cash and cash equivalents at 31 March	18	**5,426**	5,168	**1,200**	4,654

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 the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Going concern

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

The Department of Health Group Accounting Manual (GAM) 2016/17 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. However, as the Trust operated with a deficit from 2015/16 to 2016/17 and plans a further financial deficit in 2017/18 & 2018/19 the Board did have to consider the principle of going concern.

The Trust has received revenue and capital loans from the Department of Health (DOH) in 2015/16 and 2016/17 with a total value of £41.7m which enabled the Trust to meet its obligations as they fell due. The 2017/18 and 2018/19 financial plans and cash flow forecasts have been prepared on the assumption that further loan support will be received from DOH. This includes loan support to facilitate the repayment of the 2015/16 revenue loan principal of £17.5m which is due to be repaid in January 2018. The loan support planned for would cover the financial deficit after achievement of all savings plans and all performance measures for access to sustainability and transformation funding (STF). Discussions to date indicate all planned funding will be forthcoming, and any cash shortfall resulting from underachievement of savings or STF will be met by further loan facilities. These funds are expected to be sufficient to cover future financial obligations.

The Directors have concluded that there is a reasonable expectation the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. Therefore, these accounts have been prepared under a going concern basis as set out in IAS 1.

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

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 2017 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 31 March 2017 was £1.8m. 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 31 March 2017 was £0.5m.

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.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year. Except where a subsidiary's financial year end is before 1 January 2017 or after 1 July 2016 in which case the actual amounts for each month of the trust's financial year are obtained from the subsidiary and consolidated.

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.

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 and 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.

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 are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the 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 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. 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 property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at 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. The 5 yearly full valuation was carried out as at 31 March 2015.

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, 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
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 are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating 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, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware 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.

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

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.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. 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.

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.

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 20 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 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only

by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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.

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 2016/17. 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 2016/17 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.

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 accounting estimates and judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of evaluation is to consider whether there may be a significant risk of causing material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements.

Value of land, buildings and dwellings £50.6 million (2015/16: £45.8 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.

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 2016/17 financial year end, the estimated value of partially completed spells is £619,140 (2015/16: £618,325).

Untaken annual leave: Salary costs include a £403,553 estimate for the annual leave earned but not taken by employees at 31 March 2017, to the extent that staff is permitted to carry leave forward to the next financial year (2015/16: £299,875).

Provisions: Assumptions around the timing of the cash flows relating to provisions are based upon information from the NHS Pensions Agency and expert opinion within the Trust and from the external advisors regarding when legal issues may be settled.

Accounting standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC:

IFRS 9 Financial Instruments

IFRS 14 Regulatory Deferral Accounts

IFRS 15 Revenue from Contracts with Customers

IFRS 16 Leases

The above amendments and new standards have not yet been adopted within the FReM, and are therefore not applicable to the Department of Health group for 2016/17.

1.20 Accounting standards, amendments and interpretations issued that have been adopted early

The Trust has not early adopted any new accounting standards, amendments or interpretations.

2.0 Segmental Analysis

Group and Trust

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 Trust as a whole entity, not for its separate business activities. The activities of the subsidiary companies are not considered sufficiently material to require separate disclosure.

3 Operating income from patient care activities

3.1 Income from patient care activities (by nature)

	Group		Trust	
	2016/17 £'000	2015/16 £'000	2016/17 £'000	2015/16 £'000
Clinical Income				
A & E income	5,331	5,047	5,331	5,047
Elective income	20,103	17,545	20,103	17,545
Non-elective income	33,761	32,024	33,761	32,024
Other non protected clinical income	382	650	382	650
Other NHS clinical income	38,287	32,248	34,506	32,248
Outpatient income	15,685	16,648	15,685	16,648
Private patient income	2,103	2,293	2,103	2,293
Clinical income from activities	115,652	106,455	111,871	106,455

3.2 Income from patient care activities (by source)

	Group		Trust	
	2016/17 £'000	2015/16 £'000	2016/17 £'000	2015/16 £'000
CCGs and NHS England	112,637	102,710	108,972	102,710
Local authorities	29	483	29	483
Other NHS foundation trusts	59	158	59	158
NHS other	47	98	47	98
Non-NHS: private patients	2,103	2,293	2,103	2,293
Non-NHS: overseas patients (chargeable to patient)	23	78	23	78
NHS injury scheme (was RTA)	382	315	382	315
Non NHS: other	372	320	256	320
Total income from activities	115,652	106,455	111,871	106,455
Of which:				
Related to continuing operations	115,662	106,455	111,871	106,455

NHS Injury Scheme income is subject to a provision for doubtful debts of 22.94% for 2016/17 which has increased from 21.99% in 2015/16, to reflect expected rates of collection.

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are therefore no longer required.

3.3 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

Group and Trust

	2016/17 £'000	2015/16 £'000
Income from services designated (or grandfathered) as commissioner requested services	113,167	103,512
Income from services not designated as commissioner requested services	2,485	2,943
Total	115,652	106,455

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

	Trust	
	2016/17 £'000	2015/16 £'000
Income recognised this year	23	78
Cash payments received in-year	23	24
Amounts added to provision for impairment of receivables	0	54
Amounts written off in-year	29	0

4 Other operating income

	Group		Trust	
	2016/17 £'000	2015/16 £'000	2016/17 £'000	2015/16 £'000
Research and development	809	806	809	806
Education and training	4,177	4,248	4,177	4,248
Receipt of capital grants and donations	780	470	780	470
Non-patient care services to other bodies	2,524	4,072	2,524	4,072
Sustainability and Transformation Fund income	5,252	0	5,252	0
Income in respect of staff costs where accounted on gross basis	0	492	0	492
Incoming resources received by NHS charitable funds	4,038	480	0	0
Vanguard project income	3,400	4,900	3,400	4,900
Other income	8,566	4,748	9,518	4,748
Total other operating income	29,546	20,216	26,460	19,736

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

5 Operating expenses

5.1 Operating expenses comprise

		Group		Trust	
		2016/17	2015/16	2016/17	2015/16
	Note	£'000	£'000	£'000	£'000
Clinical negligence insurance		2,883	2,474	2,883	2,474
Consultancy costs		377	2,283	353	2,283
Depreciation and amortisation		4,044	3,612	4,038	3,612
Drug costs		14,282	12,881	14,282	12,881
Establishment		3,021	3,399	3,229	3,399
Fees for Audit					
- Statutory audit		56	62	56	62
- Associate Companies		11	5	11	5
- Other assurance		7	8	7	8
- Tax advisory services		128	63	128	63
- Internal audit fees		55	50	55	50
Impairments	11	788	0	788	0
Increase/(Decrease) provisions		25	255	211	255
Legal fees		355	439	355	439
Losses, ex gratia & special payments		0	10	0	10
Loss on disposal of plant, property and equipment		0	427	0	427
NHS charities expenditure		987	578	0	0
Premises		9,167	8,304	8,906	8,304
Property, plant & equipment impairments		0	0	0	0
Purchase of healthcare from non NHS bodies		2,180	1,445	2,180	1,445
Rentals under operating leases	5.3	308	98	308	98
Services from:					
- CCGs and NHS England		0	3	0	3
- NHS Foundation Trusts		3,539	2,415	3,539	2,415
- NHS Trusts		0	76	0	76
Staff costs:					
- Executive Directors'	6	1,471	1,248	1,471	1,248
- Other Staff costs	6	94,509	86,790	90,941	86,790
- Redundancy costs	6	1,054	465	1,054	465
- Non-Executive Directors' costs		104	105	104	105
Supplies and services (excluding drug costs)					
- Clinical		13,368	12,977	13,368	12,977
- General		2,405	2,228	2,305	2,228
Training		590	693	590	693
Transport		542	420	542	420
Other		464	599	617	539
		156,720	144,412	152,321	143,774

5.2 Limitation on auditor's liability

The limitation on the auditor's liability is £2,000,000. (2015/16: £1,000,000)

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 and Trust	2016/17 £'000	2015/16 £'000
Minimum lease payments	308	98
Total	308	98

	31 March 2017 £'000	31 March 2016 £'000
Future minimum lease payments due:		
- not later than one year;	381	238
- later than one year and not later than five years;	1,228	870
- later than five years.	202	203
Total	1,811	1,311
Future minimum sublease payments to be received	-	-

6 Staff costs

6.1 Staff costs

	Group		Trust	
	2016/17 £'000	2015/16 £'000	2016/17 £'000	2015/16 £'000
Salaries and wages (excluding NEDS)	73,434	66,145	70,057	66,145
Social security costs	6,618	4,796	6,620	4,796
Employer contributions to NHSPA	8,411	7,916	8,483	7,916
Termination benefits	1,054	465	1,054	465
Agency and contract staff	7,517	9,181	6,592	9,181
	97,034	88,503	92,806	88,503

6.2 Employee benefits

Benefits in kind relating to lease cars totalled £92,530 in the year (2015/16: £79,556). 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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 (England and Wales) Pension 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 next actuarial valuation is to be carried out as at 31 March 2017. 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 2016/17 there were three early retirements from the trust agreed on the grounds of ill-health (2015/16: Three). The estimated additional pension liabilities of these ill-health retirements is £96,000 (2015/16: £191,907).

9 Finance income and expenses

Group and Trust

	2016/17 £'000	2015/16 £'000
Finance Income		
Trust interest received	19	27
Charity interest received	12	3
	31	30
Finance Expense		
Interest on loan from Department of Health	(731)	(102)
Commercial Loans	(86)	0
Interest on finance leases	(68)	(69)
Unwiding of discount on provisions	0	(14)
	(885)	(185)

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

Group and Trust

	2016/17 £'000	2015/16 £'000
Loss on disposal of tangible fixed assets	0	(427)
Loss on disposal of fixed assets	0	(427)

The disposals in 2015/16 were in respect of non-protected assets.

11 Impairment of assets

Group and Trust

	2016/17 £'000	2015/16 £'000
Changes in market price	788	0
Total net impairments charged to operating deficit	788	-
Impairments charged to the revaluation reserve	608	0
Total net impairments	1,396	-

An interim desktop revaluation of the Trust's land, buildings and dwellings was carried out as at 31 March 2017.

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	2016/17 Number	2016/17 Value £'000	2015/16 Number	2015/16 Value £'000
Losses of Cash:				
Due to overpayment of salary	**7**	**13**	1	1
Bad Debts				
Private Patients	**42**	**4**	12	2
Overseas Visitors	**19**	**29**	1	0
Other	**48**	**3**	17	1
Damage to building:				
Not theft or fraud	**1**	**65**	0	0
Ex Gratia payments:				
Loss of personal effects	**40**	**9**	24	7
Other	**10**	**1**	8	0
Recovered Losses:				
Compensation Payments Received	**2**	**(10)**	0	0
Total losses and special payments	**169**	**114**	63	11

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	2016/17 Software licence £'000	2016/17 Assets under construction £'000	2016/17 Total £'000	2015/16 Software licence £'000	2015/16 Assets under construction £'000	2015/16 Total £'000
Cost or valuation at 1 April	1,669	2,455	4,124	1,579	740	2,319
Additions - purchased	13	1,541	1,554	90	1,715	1,805
Additions - donated	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Disposals	(33)	0	(33)	0	0	0
At 31 March	1,649	3,996	5,645	1,669	2,455	4,124
Amortisation at 1 April	777	0	777	467	0	467
Provided during the year	322	246	568	310	0	310
Revaluation	0	0	0	0	0	0
Disposals	(33)	0	(33)	0	0	0
Amortisation at 31 March	1,066	246	1,312	777	0	777
Net book value						
- Purchased at 1 April	892	2,455	3,347	1,112	740	1,852
- Donated at 1 April	0	0	0	0	0	0
	892	2,455	3,347	1,112	740	1,852
Net book value						
- Purchased at 31 March	583	3,750	4,333	885	2,455	3,340
- Donated at 31 March	0	0	0	7	0	7
Total at 31 March	583	3,750	4,333	892	2,455	3,347

15 Property plant and equipment

15.1 Property, plant and equipment at 31 March 2017 comprise the following elements

Group and Trust	Freehold Land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2016	4,818	51,820	1,391	1,905	16,891	5	2,091	827	79,748
Additions - purchased	0	4,351	0	416	626	0	121	131	5,645
Additions - leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	1,814	0	(1,814)	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	(461)	(3,789)	13	0	0	0	0	0	(4,237)
Revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(1,233)	0	(168)	(9)	(1,410)
At 31 March 2017	**4,357**	**54,196**	**1,404**	**507**	**16,284**	**5**	**2,044**	**949**	**79,746**
Depreciation at 1 April 2016	51	11,405	769	0	11,088	5	1,582	323	25,223
Provided during the year	0	1,987	49	0	1,239	0	126	75	3,476
Impairments	0	(1,511)	0	0	0	0	0	0	(1,511)
Reversal of impairments	0	(657)	(50)	0	0	0	0	0	(707)
Revaluation	0	(2,619)	(48)	0	0	0	0	0	(2,667)
Disposals	0	0	0	0	(1,184)	0	(168)	(6)	(1,358)
Accumulated depreciation at 31 March 2017	**51**	**8,605**	**720**	**0**	**11,143**	**5**	**1,540**	**392**	**22,456**
Net book value									
- Purchased at 1 April 2016	4,767	37,483	622	1,602	4,884	0	509	404	50,271
- Finance Leases at 1 April 2016	0	1,308	0	0	343	0	0	0	1,651
- Donated at 1 April 2016	0	1,625	0	303	575	0	0	100	2,603
Total at 1 April 2016	**4,767**	**40,416**	**622**	**1,905**	**5,802**	**0**	**509**	**504**	**54,525**
- Purchased at 31 March 2017	4,306	41,996	684	486	4,186	0	504	386	52,548
- Finance Leases at 31 March 2017	0	1,329	0	0	279	0	0	0	1,608
- Donated at 31 March 2017	0	2,266	0	21	676	0	0	171	3,134
Total at 31 March 2017	**4,306**	**45,591**	**684**	**507**	**5,141**	**0**	**504**	**557**	**57,290**

15.2 Property, plant and equipment at 31 March 2016 comprise the following elements:

Group and Trust	Freehold Land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2015	4,763	46,761	1,391	256	16,901	5	2,273	700	73,050
Additions - purchased	55	4,877	270	1,732	1,186	0	121	138	8,379
Additions - leased	0	231	0	0	0	0	0	0	231
Reclassifications	0	83	0	(83)	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0
Revised gross cost following revaluation	0	(132)	(270)	0	(1,196)	0	(303)	(11)	(1,912)
At 31 March 2016	**4,818**	**51,820**	**1,391**	**1,905**	**16,891**	**5**	**2,091**	**827**	**79,748**
Depreciation at 1 April 2015	51	9,653	719	0	10,969	5	1,747	262	23,406
Provided during the year	0	1,759	51	0	1,291	0	137	64	3,302
Impairments	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0
Revised gross cost following revaluation	0	(7)	(1)	0	(1,172)	0	(302)	(3)	(1,485)
Accumulated depreciation at 31 March 2016	**51**	**11,405**	**769**	**0**	**11,088**	**5**	**1,582**	**323**	**25,223**
Net book value									
- Purchased at 1 April 2015	4,711	34,362	672	217	4,901	0	526	371	45,760
- Finance Leases at 1 April 2015	0	1,069	0	39	408	0	0	0	1,516
- Donated at 1 April 2015	0	1,678	0	0	623	0	0	67	2,368
Total at 1 April 2015	**4,711**	**37,109**	**672**	**256**	**5,932**	**0**	**526**	**438**	**49,644**
- Purchased at 31 March 2016	4,767	37,483	622	1,602	4,884	0	509	404	50,271
- Finance Leases at 31 March 2016	0	1,308	0	0	343	0	0	0	1,651
- Donated at 31 March 2016	0	1,625	0	303	575	0	0	100	2,603
Total at 31 March 2016	**4,767**	**40,416**	**622**	**1,905**	**5,803**	**0**	**509**	**504**	**54,526**

16 Inventories

	Group		Trust	
	31 March 2017 £'000	31 March 2016 £'000	**31 March 2017 £'000**	31 March 2016 £'000
Drugs	**965**	1,107	**1,022**	1,107
Consumables	**1,060**	991	**991**	991
Energy	**2**	4	**4**	4
	2,027	2,102	**2,017**	2,102

Inventories recognised in expenses for the year were £152,000 (2015/16: £81,000).

17 Trade and other receivables

17.1 Trade and other receivables

	Group		Trust	
	31 March 2017 £'000	31 March 2016 £'000	**31 March 2017 £'000**	31 March 2016 £'000
Current				
Amounts falling due within one year:				
NHS receivables	**1,080**	1,074	**840**	1,074
Provision for impaired receivables	**(80)**	(203)	**(80)**	(203)
Prepayments	**926**	732	**911**	732
Accrued income	**5,255**	1,090	**4,704**	1,090
PDC dividend receivable	**29**	66	**29**	66
Other receivables	**1,620**	2,379	**1,943**	2,248
	8,830	5,138	**8,347**	5,007
Non-Current				
Amounts falling due after more than one year:				
Provision for impaired receivables	**(176)**	(141)	**(176)**	(141)
Other receivables	**576**	706	**576**	706
	400	565	**400**	565
Total receivables	**9,230**	5,703	**8,747**	5,572

17.2 Provision for the impairment of receivables

	Group		Trust	
	31 March 2017 £'000	31 March 2016 £'000	**31 March 2017 £'000**	31 March 2016 £'000
At 1 April	**344**	297	**344**	297
Increase in provision	**79**	473	**79**	473
Amounts utilised	**(157)**	(170)	**(157)**	(170)
Unused amounts reversed	**(10)**	(256)	**(10)**	(256)
At 31 March	**256**	344	**256**	344

An allowance for impairment is made where there is an identifiable event which, based on previous evidence that the monies will not be recovered in full.

17.3 Analysis of impaired receivables

	Group		Trust	
	31 March 2017 £'000	31 March 2016 £'000	31 March 2017 £'000	31 March 2016 £'000
Ageing of impaired receivables				
0 - 30 days	0	0	0	0
30 - 60 days	0	0	0	0
60 - 90 days	0	0	0	0
90 - 180 days	18	22	18	22
over 180 days	158	322	158	322
	176	344	176	344
Ageing of non-impaired receivables past their due date				
0 - 30 days	519	433	519	433
30 - 60 days	281	898	281	898
60 - 90 days	65	169	65	169
90 - 180 days	246	32	246	32
over 180 days	61	170	61	170
	1,172	1,702	1,172	1,702

18 Cash and cash equivalents

18.1 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 2017 £'000	31 March 2016 £'000	31 March 2017 £'000	31 March 2016 £'000
At 1 April	5,168	2,565	4,654	2,051
Net change in year	258	2,603	(3,454)	2,603
At 31 March	5,426	5,168	1,200	4,654
Broken down into:				
Cash at commercial banks and in hand	329	146	109	146
Cash with the Government Banking Service	5,097	5,022	1,091	4,508
Total cash and cash equivalents as in SoFP & SoCF	5,426	5,168	1,200	4,654

19 Third Party Assets

The Trust had cash at bank and in hand at 31 March 2017 £1,995 (£20 at 31 March 2016) in relation to monies held by the Foundation Trust on behalf of patients.

20 Trade and other payables

	Group		Trust	
	31 March 2017 £'000	31 March 2016 £'000	31 March 2017 £'000	31 March 2016 £'000
Amounts falling due within one year:				
Receipts on account	357	340	357	340
NHS payables	688	1,607	688	1,607
Trade payables - capital	1,157	2,532	1,157	2,532
Other trade payables	3,159	2,259	3,054	2,259
Other payables	863	3,016	811	3,016
Accruals	8,466	8,063	8,474	8,063
NHS Charitable funds payables	488	160	0	0
Total current payables	15,178	17,977	14,541	17,817
Amounts falling due after one year:				
Other trade payables	312	0	0	0
Total non current payables	312	0	0	0
Total payables	**15,490**	**17,977**	**14,541**	**17,817**

Other trade payables include £1,278,000 in respect of outstanding pensions contributions as at 31 March 2017 (2015/16: £1,103,000).

21 Provisions for Liabilities and Charges

Group and Trust	Pensions relating to other staff £'000	Legal Claims £'000	Other £'000	Total £'000
At 1 April 2016	255	857	0	**1,112**
Arising during the year	0	29	278	**307**
Change in discount rate	24	88	0	**112**
Utilised during the year	(24)	(60)	(10)	**(94)**
Reversed unused	(11)	(7)	(186)	**(204)**
Unwinding of discount	0	11	0	**11**
At 31 March 2017	**244**	**918**	**82**	**1,244**
Expected timing of cashflows:				
Within 1 year	24	105	0	**129**
1 - 5 years	98	219	0	**317**
over 5 years	122	594	82	**798**
	244	**918**	**82**	**1,244**

£58,703,670 is included in the provisions of the NHS Litigation Authority at 31 March 2017 in respect of clinical negligence liabilities of the Trust, (£53,707,655 for 2015/16).

21.1 Pensions relating to other staff

The cost of pensions relating to early retirements is calculated using The NHS Pension Agency capitalisation tables for the NHS Pension Scheme to determine the full liability for each employee.

21.2 Legal Claims

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

21.3 Estimation uncertainty

Amounts recorded under provisions for "Pensions relating to other staff" and "Legal Claims" include an element of uncertainty as the provision has been calculated using the English Life Expectancy statistics to estimate the length of time the liability can reasonably be expected to remain.

22 Borrowings

	Group		Trust	
	31 Mar 2017 £'000	31 Mar 2016 £'000	31 Mar 2017 £'000	31 Mar 2016 £'000
Current				
Department of Health loans	18,091	0	18,091	0
Other Loans	42	0	0	0
Obligations under finance leases	328	138	328	138
Total current borrowings	18,461	138	18,419	138
Non-current				
Department of Health loans	23,654	23,000	23,654	23,000
Other Loans	1,451	0	0	0
Obligations under finance leases	1,203	1,555	1,203	1,555
Total non-current borrowings	26,308	24,555	24,857	24,555

22.1 Finance Leases

Group and Trust	31 Mar 2017 £'000	31 Mar 2016 £'000
Gross Leases Liabilities	1,846	2,070
Not later than one year	201	200
Later than one year less than five years	725	798
Later than five years	920	1,072
Finance charges allocated to future periods	(315)	(377)
Net lease liabilities	1,531	1,693
Of which is payable		
Not later than one year	328	138
Later than one year less than five years	357	618
Later than five years	846	937
	1,531	1,693

23 Capital Commitments

There is £419,700 of capital commitments at 31 March 2017 (31 March 2016 £772,900). This is made up of the following:

ICU, CCU and ED central stations and telemetry system £144,100

The upgrade and replacement of current ICU, CCU and ED central stations and telemetry system

Public corridor lighting £89,100

The design, supply and installation of replacement lighting to public corridor lighting troughs

Other capital projects of £185,500 include:

Other commitments relate to the Colposcopy suite refurbishment, refurbishment of the research

Laboratory and Electronic Medical Equipment store room and pre-construction activities for Macmillan reception and waiting area.

24 Contingent Assets and Liabilities

There were no contingent assets and no contingent liabilities for the year ended 31 March 2017 or for the year ended 31 March 2016.

25 Movements in Public Dividend Capital

Group and Trust	2016/17 £'000	2015/16 £'000
Public dividend capital at 1 April	41,823	41,823
New public dividend capital received	41	0
Public dividend capital at 31 March	41,864	41,823

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 2017, 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 a joint venture. These entities are listed below:

2016/2017	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000
Dorset County Hospital NHS FT	151	308	13	116
Dorset University Healthcare NHS FT	1,752	397	273	90
Royal Devon and Exeter NHS FT	611	340	0	185
Gloucestershire Hospitals NHS FT	0	662	0	61
Somerset Partnership NHS FT	2,521	647	174	67
Taunton and Somerset NHS FT	573	1,416	167	29
Health Education England	4,045	0	0	0
Dorset CCG	14,815	0	7	0
Somerset CCG	85,193	224	109	75
Wiltshire CCG	334	0	18	0
NHS England (excluding STF)	15,288	108	1,073	367
NHS England (STF)	5,252	0	2,196	0
NHS Litigation Authority	0	2,883	0	0
Southwest Pathology Services (JV)	0	1,768	0	0
SPS Facilities (JV)	0	1,878	0	0
Integrated Pathology Services	270	0	0	0
Yeovil Estates Partnership LLP (YEP)	950	0	0	0
Daycase UK (DCUK)*	663	483	333	0

2015/2016	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000
Dorset County Hospital NHS FT	124	306	8	3
Dorset University Healthcare NHS FT	1,679	290	195	0
Royal Devon and Exeter NHS FT	659	359	62	22
Gloucestershire Hospitals NHS FT	5	747	5	61
Somerset Partnership NHS FT	2,568	513	452	425
Taunton and Somerset NHS FT	446	1,665	130	288
Health Education England	3,999	0	0	0
Dorset CCG	13,898	48	158	48
Somerset CCG	82,374	46	96	599
Wiltshire CCG	247	0	42	0
NHS England	11,583	6	773	7
NHS Litigation Authority	0	2,478	0	0
Southwest Pathology Services (JV)	0	1,148	0	0
SPS Facilities (JV)	0	1,751	0	0
Integrated Pathology Services	263	0	0	0

* Please note that all DCUK transactions are intercompany and are therefore eliminated

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 members of the Board of the NHS Foundation Trust. Full audited accounts are prepared for the charitable funds held by the Trust.

27 Group Structure

Yeovil Estates Partnership LLP – Company Number: OC396172

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 29 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

Wellchester Innovation Ltd was incorporated on 1 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.

Daycase UK LLP – Company Number: OC2412071

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 1 June 2016, Yeovil District Hospital NHS Foundation Trust owns 70% of the company.

Daycase UK LLP has adopted a short accounting period 1 June 2016 to 31 March 2017 to align accounting periods with the parent company.

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.

Symphony Healthcare Services Ltd – Company Number: 06633460

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. The Trust also acquired Ilchester GP practice and Buttercross Health Centre. These three practices operate as subsidiaries of Symphony Healthcare Services Ltd and their financial performance is consolidated.

As at 31 March 2017 Symphony Healthcare Services operates primary care services at three locations within Somerset, Ilchester GP practice, Yeovil walk in centre and Buttercross Health Centre.

Yeovil District Hospital NHS Foundation Trust owns 100% of the equity and no goodwill arose in respect of the acquisitions. As per the NHS Act 2006 section 259 no goodwill can arise as part of the sale of primary care businesses.

	£000's
Consideration paid	744
Net Assets Aquired	(744)
Goodwill	0

Post the balance sheet date of 31 March 2017 Symphony Healthcare Services Ltd acquired Highbridge Medical Centre on 1 April 2017 for consideration of £28k, no goodwill arose on acquisition, this company will be included within the consolidated financial performance at 31 March 2018.

Yeovil Property Operating Company Ltd – Company Number: 09958551

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 19 January 2016, Yeovil District Hospital NHS Foundation Trust owns 100% of Yeovil Property Operating Company.

Yeovil Property operating company has adopted a long accounting period 19 January 2016 to 31 March 2017 to align accounting periods with the parent company.

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.

Southwest Pathology Services LLP – Company Number: OC370482

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

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

The associate is SW Path Services LLP incorporated in the United Kingdom with its principle place of business being Somerset.

Yeovil District Hospital NHS Foundation Trust owns 15.3% of the equity of SW Path Services LLP and holds 20% of the voting rights on matters not requiring unanimous consent of members as identified within the contractual arrangements.

28 Financial Instruments

IAS 32 (Financial Instruments, Presentation), IAS 39 (Financial Instruments: Recognition and Measurement) and IFRS 7 (Financial Instruments, Disclosure) require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Due to the way that the Commissioners are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities.

Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

29 Financial Risk Management

The Trust's financial risk management operations are carried out by the Trust's Treasury Function, within the parameters formally defined within the Treasury Management Guidance, agreed by the Trust Audit Committee. Trust treasury activity is routinely reported and is subject to review by internal and external auditors.

The Trust's financial instruments comprise of cash and liquid resources and various items such as trade debtors and creditors that arise directly from its operations. The Trust does not undertake speculative treasury transactions.

29.1 Liquidity Risk

The NHS Foundation Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. Yeovil District Hospital NHS Foundation Trust has submitted an annual plan to its regulator Monitor for 2017/18 which plans for a £13.5m deficit; the Trust expects to receive cash support from the Department of Health during the year in order for it to be able to meet its cash commitments.

29.2 Interest Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest rate risk.

29.3 Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

29.4 Credit Risk

The majority of the Trust's income comes from Government bodies or other NHS organisation under contractual arrangements meaning that the Trust is not exposed to high levels of credit risk.

Other income is subject to credit control procedures which are regularly reviewed by management. Outstanding debtors are referred to a credit collection agency once the Trust has exhausted all other methods of collection.

29.5 Price Risk

The Trust invests its surplus cash in Government Banking Services Accounts (GBS) therefore it is not subject to market price risk.

29.6 Cashflow Risk

Cash is invested in accordance with approved procedures. Cashflows are monitored and weekly forecasts are produced to ensure commitments are met.

29.7 Financial Assets

Group and Trust	Carrying Amount 31 Mar 2017	Fair Value 31 Mar 2017	Carrying Amount 31 Mar 2016	Fair Value 31 Mar 2016
	£'000	£'000	£'000	£'000
Trade and other recievables	8,830	8,830	3,684	3,684
Cash at bank	5,426	5,426	5,139	5,139
	14,256	14,256	8,823	8,823

29.8 Financial Liabilities

Group and Trust	Carrying Amount 31 Mar 2017	Fair Value 31 Mar 2017	Carrying Amount 31 Mar 2016	Fair Value 31 Mar 2016
	£'000	£'000	£'000	£'000
Borrowings	41,745	41,745	23,000	23,000
Finance Lease	1,531	1,531	1,693	1,693
Other creditors	16,963	16,963	8,306	8,306
Provisions	1,244	1,244	1,112	1,112
	61,483	61,483	34,111	34,111

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.