

# Annual Report and Accounts 2016/17





**Dorset County Hospital NHS Foundation Trust**

**Annual Report and Accounts 2016/17**

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



# Contents

**Performance Report .....1**

Overview of the Trust ..... 1

Performance Analysis ..... 15

**Accountability Report ..... 26**

Directors’ Report ..... 26

Remuneration Report ..... 27

Staff Report ..... 39

Disclosures ..... 53

Regulatory Ratings ..... 71

Sustainability ..... 73

Statement of Accounting Officer’s Responsibilities ..... 83

Annual Governance Statement ..... 85

**Quality Report ..... 97**

**Accounts ..... 164**

# Performance Report

## Overview of the Trust

### Statement from the Chairman and Chief Executive

This has been another extremely busy year for Dorset County Hospital but our committed and resilient staff have continued to strive to provide the very best care for our patients.

The NHS is under more pressure than ever before with rising demand on services and stretched resources. Despite this our staff have managed to improve the hospital's performance in key areas. Our four-hour wait performance in the Emergency Department has steadily improved and by the end of the year we were regularly among the top five performing hospitals in the country. We also achieved all the cancer standards by the final quarter thanks to the focus of our dedicated multi-disciplinary team. We are keenly aware though that there is always room for improvement and our teams greatly value feedback from patients to understand where we can do better.

Our financial situation continues to be challenging but we remain focused on quality, financial sustainability and value for money. We recognise we cannot do this alone and we cannot carry on doing things the way we have always done. We need to work more closely with our local partner organisations to join up health and care services so they work better for our patients and more efficiently.

We have made real progress locally this year. Dorset's health organisations and local authorities have worked together to develop a Sustainability and Transformation Plan (STP) for the county. This outlines how we will work together to join up services and the Dorset Clinical Commissioning Group's Clinical Services Review (CSR) will feed into this work.

We have also made great strides in collaborating with our neighbouring hospitals to create a local network of acute services. The Developing One NHS in Dorset vanguard programme has seen clinical teams from Dorset County Hospital, Poole Hospital and The Royal Bournemouth and Christchurch Hospitals come together to improve access to quality services for patients throughout the county.

We were thrilled to be able to open new facilities at Dorset County Hospital this year, including a wonderful new suite for children's end of life care on Kingfisher Ward. We also opened a second cardiac catheter lab, allowing us to offer an improved cardiology service. In addition, we launched a fantastic new minor surgical procedure suite to accommodate procedures which do not require a full operating theatre. We are also very much looking forward to opening a new radiotherapy unit and outpatients department for cancer patients at Dorset County Hospital – made possible by a partnership with Poole Hospital and the incredible generosity of the late Robert White, a local businessman who pledged millions of pounds to improving cancer services in Dorset.

The fundraising campaign for our new outpatients suite and improved chemotherapy unit is in full swing and we are very grateful for the amazing support of the many local community and charitable organisations in helping us raise the necessary funds. There are many individuals and organisations to thank and our charity's own annual report will celebrate their enormous contribution.

Many of the new developments at Dorset County Hospital are made possible by the generosity of charitable groups and we are very appreciative of their continued support. We have also teamed up with charities this year to offer additional services, such as the 'Support at Home Service' run with the British Red Cross to help people settle back into their usual routines and regain their independence after a stay in hospital. We have also launched a new support service for eye patients thanks to a collaboration with The Dorset Blind Association.

We were delighted to receive more accolades this year for the high standards at Dorset County Hospital. We were named one of the Comparable Health Knowledge System (CHKS) Top Hospitals and performed well in all areas of the Patient-Led Assessments of the Care Environment (PLACE).

We also received the results of our Care Quality Commission (CQC) inspection. Inspectors gave us a rating of 'Requires Improvement' overall but we were really pleased to see so many areas of excellent practice highlighted, with our services rated 'good' for 'caring' across the board. There is a lot of work going on within the Trust to follow up on the areas identified for improvement and we are looking forward to welcoming inspectors back to demonstrate the progress made.

You can read more about our achievements in this Annual Report, all of which reflect the ongoing hard work and enthusiasm of our amazing staff. We feel very grateful and privileged to work with such an incredible team.

Mark Addison  
Chairman

Patricia Miller  
Chief Executive

## Highlights of the Year

### April 2016



We opened a new facility for children's end of life care on Kingfisher Ward. The Gully's Place suite offers children and their families a comfortable and peaceful space to stay with the full support of Kingfisher staff.

We wrapped up our 175<sup>th</sup> anniversary celebrations with a concert at Dorset County Museum. Tim Laycock and the Ridgeway Singers performed original music based on an oral histories project which collected the memories of former hospital staff. Concert attendees also walked the new Treves Trail, a geocaching route which traces the footsteps of 19<sup>th</sup> century surgeon Sir Frederick Treves.

Together with Dorset Police we were presented with a Trauma, Audit and Research Network (TARN) award in recognition of our efforts to identify those who are most at risk of serious injury on the roads of Dorset and educating road users, in particular motorcyclists.



We launched our £1.75million Cancer Appeal to raise money for a new cancer outpatients department and improved chemotherapy facilities as part of the project to build a radiotherapy unit at Dorset County Hospital.

### May 2016



We were named one of the Comparable Health Knowledge System (CHKS) Top Hospitals for 2016, an accolade awarded to the top 40 performing CHKS client trusts. CHKS provides healthcare intelligence and quality improvement services to the NHS. Its annual awards are based on the evaluation of over 20 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.



We assisted with the launch of a new app for Dorset mums-to-be which gives them information to help decide where they want to give birth. The My Birthplace app has been expanded to include information on hospitals in the Wessex area, including our maternity unit and Cygnet Homebirth Team.

### June 2016



Staff, parents and children gathered at our Children's Centre to celebrate the first anniversary of the Cygnet Homebirth Team. In a short space of time the dedicated team has been instrumental in increasing homebirths from two per cent to six per cent, giving Dorset County Hospital one of the highest homebirth rates in the country.

A collaboration was launched between Dorset County Hospital, Dorset and Somerset Air Ambulance, Devon Freewheelers, South Western Ambulance Service and the Henry Surtees Foundation to allow the fast transportation of blood products to accident scenes. 40% of trauma deaths are due to bleeding so being able to carry and administer blood products to patients before they get to hospital can make the difference between life or death.

A partnership between Macmillan Cancer Support and Dorset County Hospital saw the launch of new weekly drop-in information sessions for cancer patients at venues throughout the county. The information points in local libraries and community hospitals offered a range of information materials as well as a trained volunteer or member of staff who could provide a listening ear and signpost to other local services.

### July 2016



We were pleased to be able to offer an improved cardiology service with the opening of a second cardiac catheter lab. The second lab has allowed the cardiology team to reduce waiting times for procedures and recruit another cardiologist. It has also provided the capacity to allow the refurbishment of the first lab to bring it up to the high specifications expected today.



Dorset County Hospital staff and volunteers received well-deserved recognition at the 2016 GEM (Going the Extra Mile) Awards. The awards are presented annually to people who have made an outstanding contribution.

### August 2016

Patients coming to Dorset County Hospital can be assured of high standards in cleanliness, food, privacy and the environment according to the latest national scores. We performed well in all areas in the 2016 Patient-Led Assessments of the Care Environment (PLACE), with all scores above or in keeping with the national average.

Care Quality Commission (CQC) inspectors rated Dorset County Hospital as 'Requires Improvement' overall, but we were really pleased to see many areas of excellent practice highlighted. Our services were rated 'good' for 'caring' across the board. Services for children and young people received particular praise, achieving 'good' for all of the areas assessed.

### September 2016



We opened a new minor surgical procedure suite thanks to charitable support. Funding from the Friends of Dorset County Hospital and the Fortuneswell Trust allowed an area of East Wing to be redeveloped to further improve the services offered to patients. The light and airy procedure room and supporting facilities will accommodate minor surgical procedures.

### October 2016



We staged our popular annual open day which offers visitors a chance to see behind the scenes of their local hospital. Hundreds of people attended to view display and demonstrations, and to tour departments not usually open to the public.



We launched a new support service for critical care patients. The Critical Care Follow-up Team are now running a special clinic for patients who have been admitted to the Critical Care Unit, and their families, to ensure people are recovering well physically and psychologically.

Two of our doctors were shortlisted for national awards for providing outstanding customer service. Emergency Department doctor Dr Richard Huppertz and consultant paediatrician Dr Phil Parslow were finalists in the national WOW! Awards. The WOW! Awards recognise exceptional customer service and were introduced at DCH to give patients and staff the opportunity to recognise those who had cared for them and colleagues.



Our staff brought science to life for students from Dorchester's Thomas Hardy School during a visit to the diagnostic imaging department. The medical physics and diagnostic imaging teams showed students how diagnostic tests are performed and the type of equipment that is used. The students were also given an insight into the science behind the technology.

### November 2016



We teamed up with the British Red Cross to offer a new support service for patients in their own homes. The 'Support at Home Service' volunteers assist patients, mostly people over 65, in the period immediately following a stay in hospital to help them settle back into their usual routines and regain their confidence and independence.

Our Acute Hospital at Home team were presented with a national Fab Award in recognition of their fantastic work establishing a successful service to provide aspects of inpatient care in patients' own homes. The Fab Awards celebrate best practice and innovation happening across the NHS and social care.

### December 2016



Staff received recognition for their dedication at the 2016 Dorset County Hospital Long Service Awards. Certificates, medals and pin badges were presented for 25 years' service and over.



Our organ donation team asked people to think about the gift of organ donation as they switched on their Christmas tree lights. The team sponsors a tree each year to highlight the importance of people discussing their wishes around organ donation with their family. The lights for the tree were kindly donated by local firm Knighton Plumbing and Heating.



### March 2017

We marked global Nutrition and Hydration Week with a series of special events. Our dietetics and catering teams staged information and tea party events to spread the word about the importance of food and drink in relation to physical and mental wellbeing.



We teamed up with the Dorset Blind Association to improve support for eye patients with the creation of a new joint post. The Eye Clinic Liaison Officer will act as the link between the eye department and services available for people with sight problems, and offer emotional and practical support.

## About the Trust

### Introduction

Dorset County Hospital NHS Foundation Trust's purpose is to deliver compassionate, safe and effective healthcare – providing and enabling outstanding care for our patients and communities in ways which matter to them. We are the acute and specialist healthcare provider for our communities, delivering high quality care to meet our patients' expectations.

Dorset County Hospital NHS Foundation Trust ("the Trust") achieved Foundation Trust status on 1 June 2007 under the Health and Social Care (Community Health and Standards) Act 2003. The Trust took over the responsibilities, staff and facilities of its predecessor organisation, West Dorset General Hospital NHS Trust.

The Trust is the main provider of acute hospital care to the residents of West Dorset, North Dorset, Weymouth and Portland, a population of approximately 215,000 people. It also provides specialist services to the whole of Dorset and beyond including renal services in Bournemouth and Poole, and South Somerset. It serves an area with a higher than average elderly population and lower than average proportion of school aged children. Dorset continues to experience an increasing total population. The main hospital site is situated close to the centre of the county town of Dorchester. It opened in 1987 and is a modern, attractive 365 bed hospital.

The geographical spread of the community the Trust serves requires it to deliver community based as well as hospital based services. This is achieved through providing services in GP practices, in patient homes through Acute Hospital at Home and Discharge to Assess, and at community hospitals in West Dorset, including Weymouth Community Hospital, Bridport Community Hospital, the Yeatman Community Hospital in Sherborne and Blandford Community Hospital. The Trust also works closely with social services to ensure integrated services are provided.

As an NHS Foundation Trust, we are accountable to Parliament, rather than the Department of Health, and regulated by NHS Improvement. We are still part of the NHS and must meet national standards and targets. Our governors and members ensure that we are accountable and listen to the needs and views of our patients.

The Trust provides the following services for patients:

- Full Emergency Department services for major and minor accidents and trauma;
- Emergency assessment and treatment services, including critical care (the hospital has trauma unit status);
- Acute and elective (planned) surgery and medical treatments, such as day surgery and endoscopy, outpatient services, services for older people, acute stroke care, cancer services and pharmacy services (not an inclusive list);
- Comprehensive maternity services including a midwife-led birthing service, community midwifery support, antenatal care, postnatal care and home births. We have a Special Care Baby Unit and a Neonatal Intensive Care Baby Unit;

- Children's services, including emergency assessment, inpatient and outpatient services;
- Diagnostic services such as fully accredited pathology, liquid based cytology, CT scanning, MRI scanning, Ultrasound, Cardiac Angiography and interventional radiology;
- Renal services to all of Dorset and parts of Somerset;
- A wide range of therapy services, including physiotherapy, occupational therapy and dietetics; and
- An integrated service with social services to provide a virtual ward enabling patients to be treated in their own homes.

## Strategy and Objectives

### 2016-2021 Strategic Direction

The Trust has submitted its operational plan for 2017-2019 to its regulator; this plan outlines the Trust's commitment to the provision of safe, high quality care and improving its current Care Quality Commission rating from 'Requires Improvement' to 'Outstanding'. The plan is based on delivering the anticipated levels of demand in line with all national quality and performance standards in the most cost efficient manner.

The Trust is part of the Dorset Clinical Services Review and the Dorset Sustainability and Transformation Plan both of which seek to ensure a sustainable health system for Dorset. We are working closely with our partners to design and deliver a health system which meets the needs of our population in a sustainable and efficient way.

Our mission is to play a leading role, in collaboration with our partners, in the development of an integrated, patient-centred health and care system.

The key principles which underpin the vision are:

Increased focus on prevention with a radical upgrade of prevention and public health with campaigns focusing on smoking, obesity and other major health risks;

Empowering patients, giving them greater control of their own care, including shared budgets covering both health and social care;

The NHS will seek to deliver more care locally and also break down the barriers between organisations delivering care;

Our strategy is aligned with the Five Year Forward View and we are already working closely with our partners in health and social care to integrate services in Dorset.

The Trust's Strategic Objectives are by 2020 to be:

**Outstanding: Delivering outstanding services every day**

We will be one of the very best performing Trusts in the country, delivering outstanding services for our patients

**Integrated: Joining up our Services**

We will drive forward more joined up patient pathways, particularly working more closely with and supporting GPs

**Collaborative: Working with our Patients and Partners**

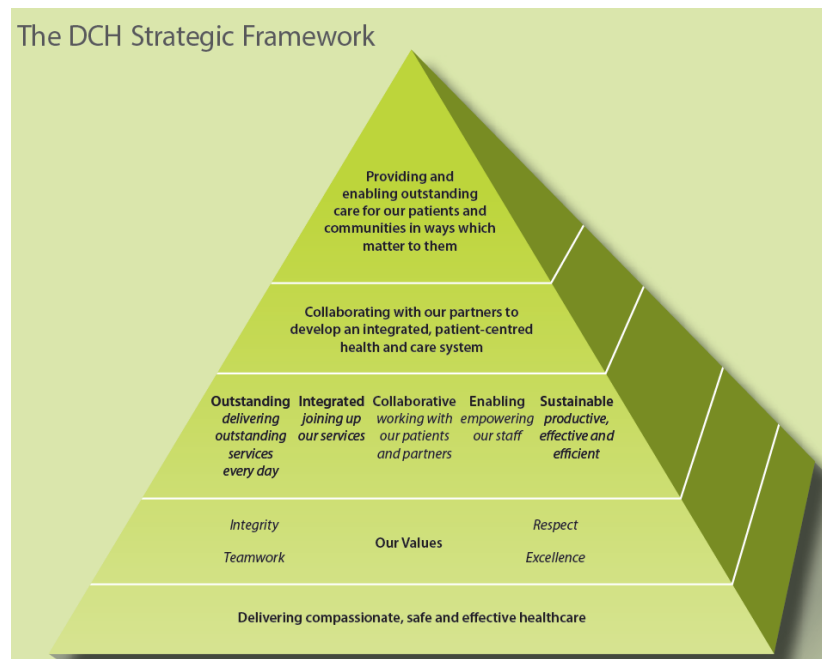
We will work with all of our partners across Dorset to co-design and deliver efficient and sustainable patient-centred, outcome focussed services

**Enabling: Empowering our Staff**

We will engage with our staff to ensure our workforce is empowered and fit for the future

**Sustainable: Productive, Effective and Efficient**

We will ensure we are productive and efficient in all that we do to achieve long-term financial sustainability



The Trust's operational and strategic plans are aligned to the Sustainability and Transformation Plan and delivery mechanisms such as the Acute Care Collaborative Vanguard.

## Key Issues and Risks

There are a number of key issues and risks which may impact on the success of the Trust.

### The National Picture

The NHS is currently facing rising and unsustainable costs to meet increasing demand, while trying to improve the quality and consistency of care and health outcomes. Additionally, the rapid pace of change in technology has further deepened the general trend of increasing patient and public expectations of the quality, closeness and timeliness of service delivery.

**Five Year Forward View** - the NHS Five Year Forward View was published in 2014 and details how health and social care will be delivered in the next five years. This was the first time all the regulatory bodies came together to develop a shared approach to service delivery and this collective vision has become the basis of planning for the delivery of healthcare in England. The Five Year Forward View warned that a combination of growing demand and limited funding could produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. To deal with this, the document proposed a three pronged approach of demand management, improved efficiency and, if these two are delivered, an increase in funding from central government.

**NHS Finances** - the NHS must deliver £22 billion of savings by 2021. By 2021 Dorset is forecast to have a deficit of approximately £221 million across the health economy if no changes are made. Without significant efficiencies being delivered immediately, demand for services will continue to outgrow the funding available.

**External regulation and oversight** - a number of national bodies exist which provide oversight and inspection of the Trust's activities. Changes in policy or approach or decisions to intervene in Trust operations, from these bodies, which may be influenced by various external or internal factors, may affect the delivery of the Trust's objectives.

**Delivery of the Acute Care Collaborative Vanguard** - this is a key component of meeting the quality and sustainability challenge for the Trust and we are committed to the ongoing success of the programme.

### Local challenges and opportunities

**Dorset Clinical Commissioning Group's Clinical Services Review** - between 1 December 2016 and 28 February 2017 NHS Dorset Clinical Commissioning Group (CCG) undertook a public consultation on proposals developed under the Clinical Services Review (CSR). During the consultation thousands of people had their say on proposals for specific roles for hospitals in Poole and Bournemouth, as well as community services and the redistribution of beds in the county. The Trust supports the CSR case for change and welcomes the proposed designation for Dorset County Hospital as the 'planned care and emergency hospital with 24/7 A&E' as we believe this is best for our local population. This means we will continue to provide the district general hospital services we currently deliver to our patients under the CSR proposals. In terms of the options for the siting of the major emergency centre in the east of the county, we believe both proposed options are possible. We accept the CCG's preferred option of the major emergency hospital at Bournemouth



Hospital with the major planned care hospital at Poole Hospital, due to the analysis and evaluation showing this option as a more accessible and affordable option.

If we are to achieve our ambitions and support Dorset CCG in improving the health of the Dorset population, there are a number of challenges that we will need to address.

**The health and wellbeing gap** - we must work with Dorset CCG to target the high areas of disease and illness within the county and we must focus our attention on these high-cost, high-impact areas. Stroke, diabetes, respiratory and heart disease are all due to increase by 12-20% over the next 10 years, while the impact of lifestyle factors leading to obesity will lead to an increase in conditions such as osteoarthritis, hypertension, diabetes and all cancers.

**Ageing population** - Dorset's ageing population will result in increased demand from patients for our services.

**Quality** - although externally Dorset County Hospital has a good reputation for delivering high quality services, much needs to be done internally to ensure that robust assurance processes are in place. We need to move towards a culture of continuous quality improvement.

**Finances** - the financial constraints that will be experienced by the NHS over the coming years will require Trusts to take a different view on how sustainability will be achieved. Partnership working with the development of commercial approaches are likely to become the foundations of how services are delivered going forward, underpinned by a relentless focus on efficiency and value for money.

**Workforce** - there are ongoing challenges in recruiting sufficient numbers of nurses to match turnover and staff escalation capacity when required. In addition the national shortage of junior doctors means that hospitals of our size are affected disproportionately. Alternative workforce models are therefore required to ensure our services continue to be safe and accessible.

**Informatics** - in line with the national ambition around digitisation we need to make significant progress towards becoming paper light. We have started the implementation of a Digital Care Record and will continue over the next few years to ensure the quality of services is improved and efficiencies made through the removal of paper clinical records.

**Care closer to home** - the NHS Five Year Forward View firmly sets a path for delivering services on an integrated basis. Secondary care can and should play an important part in the delivery of care closer to home and preventing unnecessary admissions to hospital. Acute services have more work to do to show how they can contribute greatly to this challenging agenda to ensure that services across Dorset are high quality and truly patient-centred, and achieve maximum levels of efficiency.

**Partnership and collaboration** - we are recognised for our ability and willingness to work with partners to ensure the delivery of high quality services. We must build on these partnerships, particularly strengthening our relationship with GPs if we are to be seen as a credible provider of integrated care.

**Pace of change** - the financial challenges facing us mean that we need to focus on ensuring our short-term sustainability, while also delivering long-term transformation. These must be delivered in parallel. We must be flexible and respond and adapt quickly to emerging priorities.

## Going Concern Statement

International Accounting Standard 1 (IAS1) requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust recorded an operating deficit in 2015/16 of £5.5 million and is reporting a deficit of £1.1 million for the year ended 31 March 2017. The Trust anticipates incurring a further deficit of £2.9 million in delivering services in 2017/18 and will need to apply for Financial Support through a working capital loan anticipated to be to the value of £2.5 million. It anticipates this deficit position will continue during 2018/19 and that it may take some time before it can achieve financial balance on a sustainable basis. The Board of Directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern.

Nevertheless, the Directors have concluded that assessing the Trust on the going concern basis remains appropriate. The Trust has agreed contracts with its local commissioners for 2017/18 and services are being commissioned in the same manner for 2017/18 as in previous years and there are no discontinued operations. Similarly no decision has been made to transfer services or significantly amend the structure of the organisation at this time. The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health (NHS Act 2006,s42a) to continue to deliver the full range of mandatory services for the foreseeable future.

The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the accounts and has not included the adjustments that would result if it was unable to continue as a going concern. The assessment accords with the statutory guidance contained in the NHS Foundation Trust Annual Reporting Manual.

# Performance Analysis

## Performance Measures

### Monitoring Trust Performance

In 2016 there were a number of changes to the regulation and monitoring of NHS providers. NHS Improvement was formed by bringing together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams. NHS Improvement now oversees Foundation Trusts, those Trusts that have yet to achieve that status and Independent providers. In April 2016 all Trusts were required by NHS Improvement to agree performance improvement trajectories for the four key performance indicators (Emergency Department (ED), Referral to Treatment, Cancer Waiting Times and Diagnostic Waiting Time standards) as part of a wider agreement underpinning Sustainability and Transformation Funding.

As part of its role to provide strategic leadership, oversight and practical support for Trusts, in October 2016, NHS Improvement launched a Single Oversight Framework. The aim of the Framework is to stimulate an improvement movement in the provider sector, helping providers build improvement capability, so they are equipped and empowered to help themselves and, crucially, each other. The Single Oversight Framework does not give a performance assessment in its own right, nor is it intended to predict the ratings given by the Care Quality Commission. NHS Improvement's aim, however, is to help providers attain, and maintain, CQC ratings of 'Good' or 'Outstanding'.

In response to an independent review of governance processes, the CQC final report and in order to bring the Trust in line with the Single Oversight Framework, Dorset County Hospital has gone through a significant shift in its approach to all forms of governance and this includes the monitoring, analysis and reporting on performance. There is a highly detailed balanced scorecard mapped to the CQC domains overlaid by the measures identified in the Single Assessment Framework which is used to inform Divisional Performance Reviews, Finance and Performance monthly meetings and the bi-monthly Board meetings. A Performance Management Framework has been launched in late 2016/17 which is closely aligned to the Single Oversight Framework and supports the Trust to ensure Divisions are well-led and working towards earned autonomy.

## Trust Performance

### Our Performance

Given the increasingly challenging environment in which acute trusts work, the improvements seen in operational performance in 2016/17 are testament to the dedication of hard working staff throughout the Trust, working together to achieve good outcomes for patients wherever possible.

## **Emergency Department**

Following a particularly difficult winter period in 2015/16 the Trust started this financial year with ED performance significantly below the required standard and the standard required by the NHS Improvement trajectory. A Patient Flow Transformation Program was launched, which brought together many concurrent projects into a cohesive plan to address internal constraints to good patient flow and to form links with the emerging Accountable Care Partnership (ACP). The ACP brought together health and social care partners for West Dorset to pursue agreed actions to address delayed transfers of care across the sector. Together these two initiatives sought to improve joint working throughout West Dorset to enable patients to make best use of available emergency care provision, remain in acute care for only as long as was necessary and to be safely transferred to a more appropriate care setting at the earliest opportunity. As a result of this fully collaborative approach the Trust saw improvement in ED performance by the beginning of Quarter 3 and was regularly reported in the top five performing Trusts by the end of the Quarter and throughout the final Quarter of the year. Consequently the Trust met the Year to Date NHS Improvements requirement in addition to meeting the ED standard for Quarters 3 and 4.

## **Cancer Waiting Times**

At the beginning of 2016/17 the Trust struggled to achieve the key standard of 62 days referral to treatment following an urgent referral by GP. Predominantly the prostate pathway, where patients required complex treatments such as brachytherapy or robotically assisted radical prostatectomy had long waiting times at tertiary centres for the first treatment. Pathway and waiting time work, which had begun in the previous financial year, came to fruition during Quarter 1 of the year and as a consequence the Trust achieved the standard for the following three Quarters.

The Trust met all the 2 week wait and 31 day Standards for each quarter in 2016/17. The 62 day screening standard was attained with the exception of Q3. This was disappointing but was due to a small number of overall treatments and 3 patients not being treated within 62 days - 1 due to compliance and 2 due to late transfers from other providers to this Trust for treatment.

The Trust achieved all cancer standards in Q4 which was a noteworthy achievement against a national and local health economy struggling to meet these requirements. This has been due in part to the work of the Multi Disciplinary Team (MDT) ensuring service managers are sighted on issues early and escalating serious concerns to senior managers. The team also provided insight into how small changes to pathways could speed up certain stages of the patient's journey.

As a healthcare community, much work has taken place this year to improve how providers across Dorset can work more collaboratively to deliver services for patients, regardless of which part of the Dorset they live in or where treatments are planned to take place. A new lung pathway has been developed in collaboration with the CCG and three acute trusts in Dorset. DCH has been the first to implement the changes which we hope will deliver a faster diagnosis for patients. Work is also being undertaken on Urology pathways as part of demand and capacity work across providers with particular focus on the prostate pathway.

The Chief Executives of Poole, Dorset County and Royal Bournemouth and Christchurch FT Hospitals and Dorset Clinical Commissioning Group agreed to pull together cancer resources to act as one to bring about transformational change. It was agreed that the Dorset Cancer Alliance would be reformed to become the Dorset Cancer Partnership Steering Board (The DCPSB). The DCPSB is responsible for advising/making recommendations to the Dorset Sustainability and Transformation Plan (STP) on all aspects of cancer for transformation, planning, strategic development, investment and delivery of the recommendations of the national independent cancer taskforce to 2020.

Improving patient experience has also been an important focus with the Dorset Cancer Partnership Engagement Group being established as a sub group of the Dorset Cancer Partnership Steering Board with a special focus on improving patient experience through support, guidance and communication tailored to needs.

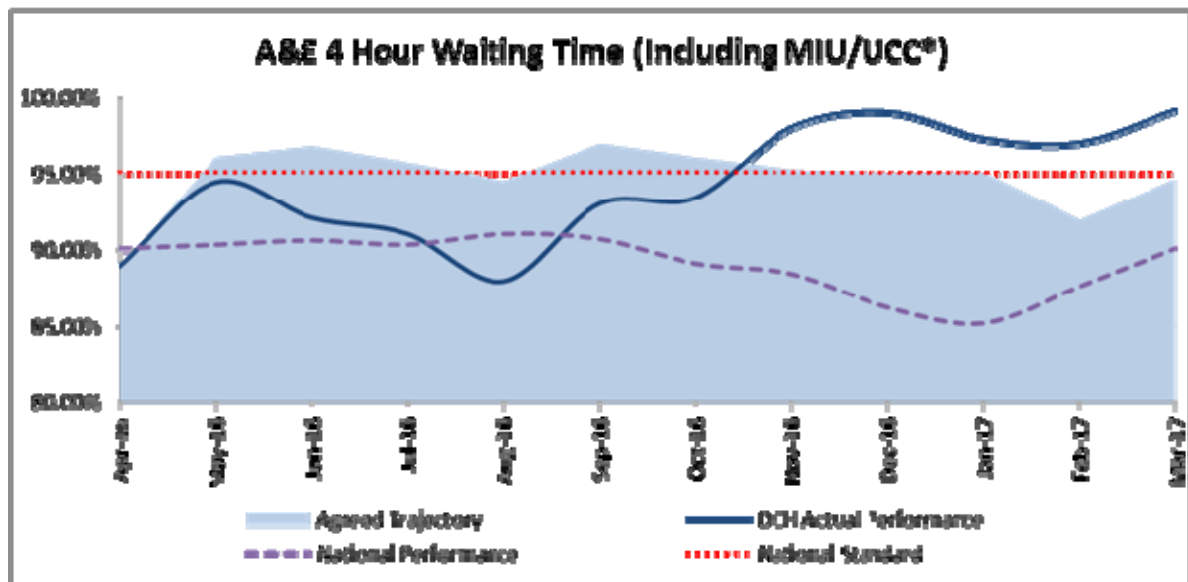
### **Referral to Treatment**

Improvement against this standard has been extremely challenging both nationally and locally. The Trust has focused on modernisation of pathways in order to better manage rising demand and workforce constraints in numerous areas. Ophthalmology is the area undergoing most scrutiny. The service has been unable to achieve the required 18 week referral to treatment (RTT) standard for over two years and is the most significant contributor to the under-performance against the RTT standard. Investment in Optometrist, Orthoptist and nursing skills has taken place during 2016/17 along with development of links with the Local Optometry Committee in order to support non-consultant led pathways and care closer to home for patients in follow up pathways. As these changes embed it is expected that consultant time will be refocussed on diagnosis of new patients and surgery where required, leading to faster routes to treatment and more convenient follow up care packages.

Intensive work to reduce waiting times during Quarter 4 of 2016/17 delivered improved performance across the specialties and a good foundation for continued improvements in performance in the next financial year.

### **Summary**

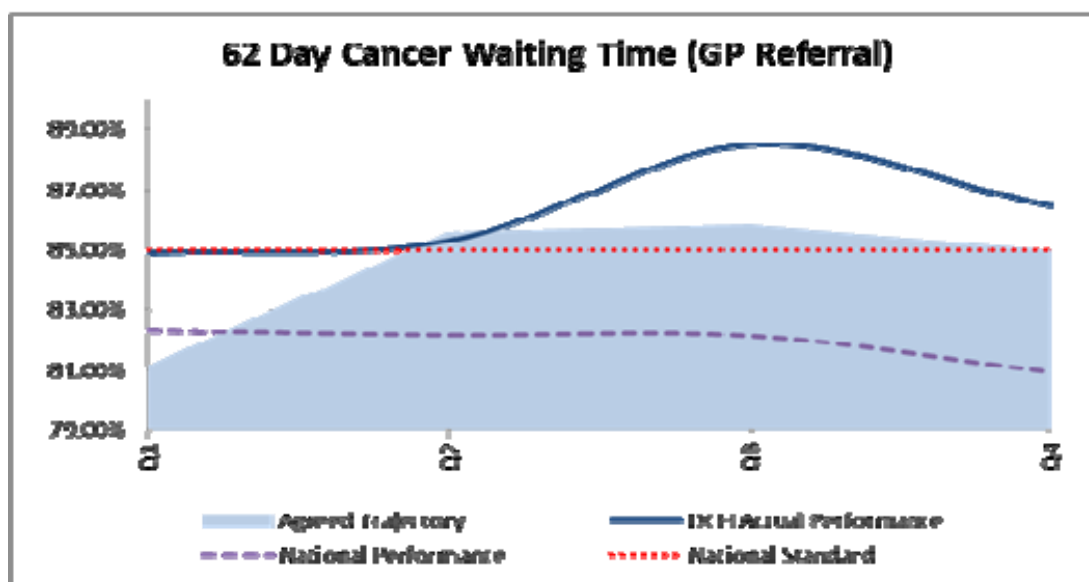
The Trust began the year in a very challenging position with waiting times requiring significant improvement across the key standards. At the end of the 2016/17 financial year the Trust was proud to announce it had met three of the four waiting time standards and made a significant improvement in the fourth. In the ED 4 hour waiting time standard this has meant that unlike the national reports, patients attending for emergency care in West Dorset have experienced excellent access times consistently since October 2016:



\*MIU/UCC – patients attending minor injury units in West Dorset and the Urgent Care Centre in Weymouth are included in the data

The ED standard can be taken as a barometer for the flow through the hospital for non-elective admissions and for the relationship with partners in health and social care provision in the locality. It is only with sufficient capacity, agreed pathways and good working relationships that an ED can productively function and ensure that those that require either admission or urgent follow up by an appropriate service are assessed and supported to do so within the maximum waiting time.

Dorset County Hospital is also extremely proud of the improvements to the management of patients referred for suspected cancer. In order to meet this exacting standard the Trust has worked in harmony with other Trusts to agree standardised pathways, reporting, escalation policies and support to expand available capacity to meet rising demand. As can be seen in the graph below, waiting times for patients referred to Dorset County Hospital significantly exceeded the national minimum standard and the national reported level of compliance with that standard.



Both the ED and 62 day from GP referral to Treatment Cancer waiting time standards are predicated on clinical evidence that these short waiting times deliver better outcomes for patients. Dorset County Hospital has therefore contributed to both improved patient experience and outcomes for our patients over the past year.

## Our Financial Performance

In 2016/17, the Trust's financial plan recognised the increased demand for NHS services, bringing with it increasing financial pressures, which are being experienced across the country. Therefore the Trust's plan, highlighted significant financial challenges in delivering a deficit of £2.2 million excluding charitable donations.

The Trust delivered an actual underlying deficit of £1.4 million. This equates to approximately 0.8% of the Trust's turnover, before accounting for receipt of £0.4 million of capital donations, non-operating items of £0.1 million, and the net impact of the revaluation of Trust's assets of £3.1 million. In total this has led to a surplus in total comprehensive income for the year of £2.0 million.

In achieving this result, the Trust delivered £6.8 million of efficiencies and savings, equivalent to 4.0% of 2016/17 income. This compares with the planned efficiency improvement target for the year of £6.7 million.

The Trust's income position exceed our planned income for the period by £4.9 million, of which £1.2 million related to the transfer of commissioning responsibility for the Minor Injuries Units in West Dorset to the Trust and £0.6 million to additional Sustainability and Transformation Fund income. Expenditure was £4.5 million above plan, excluding non-operating items and impairments.

The Trust's depreciation and amortisation charge was £0.3 million below plan and the dividend on Public Dividend Capital costs was £0.1 million below plan. The Trust's financial charges, including interest on loans from the Department of Health, were in line with plan.



The underlying deficit incurred in 2016/17 was primarily due to the following factors:

- Inability to deliver the required level of cost improvement year on year through Trust-wide schemes alone
- Premium cost of agency staff to maintain safe staffing levels.

Table 1 compares the 2016/17 outturn to the 2016/17 plan.

Table 1	2016/17 Plan £ millions	2016/17 Actual £ millions	Variance £ millions
Total income excluding capital donations and revaluation	165.9	170.8	4.9
Expenses excluding depreciation and impairments	-159.8	-164.3	-4.5
Depreciation	-5.5	-5.2	0.3
<b>Operating Deficit excluding capital donations, revaluation and impairments</b>	0.6	1.3	0.7
PDC	-2.8	-2.7	0.1
Finance income	0.1	0.1	0.0
Finance expenses	-0.1	-0.1	0.0
<b>Underlying Deficit</b>	-2.2	-1.4	0.8
Capital donations	0.4	0.4	0.0
Impairments and non-operating items	0.0	-0.1	-0.1
Revaluation	0.0	3.1	3.1
Total comprehensive income for the year	-1.8	2.0	3.8

## Investment in Developments

In 2016/17 the Trust invested in a number of services. These included investment in additional ward staffing for quality and safety and the establishment of a second cardiac catheter laboratory.

## Trends in Activity, Income and Expenditure

Charts 1 to 5 below show the trends in patient activity and income and expenditure over the five-year period from 2012/13 to 2016/17.

### Trends in Activity, Income and Expenditure (Five Years)

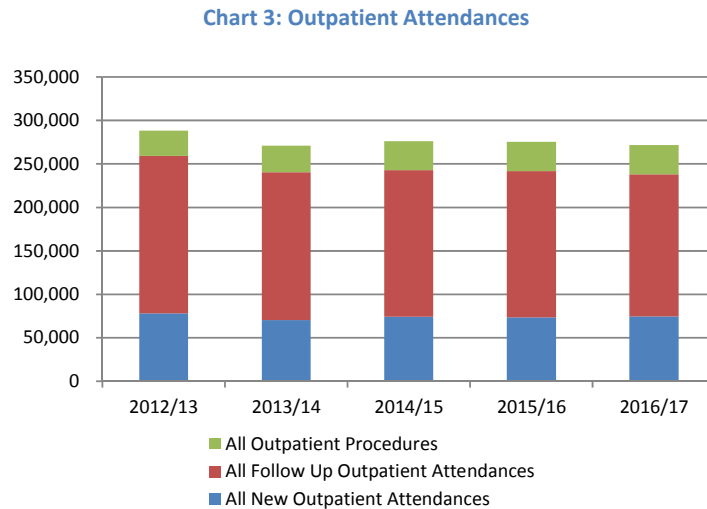
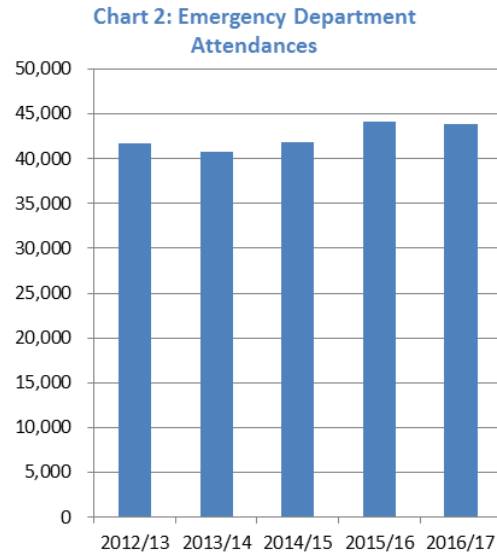
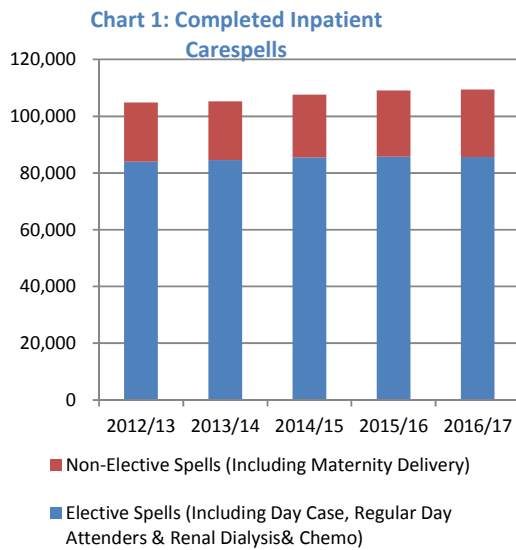


Chart 4: Income £000s

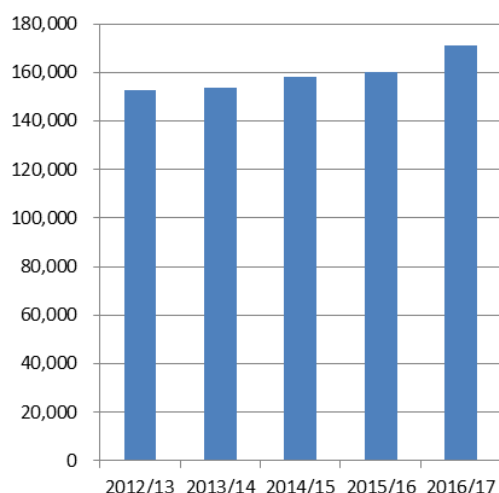
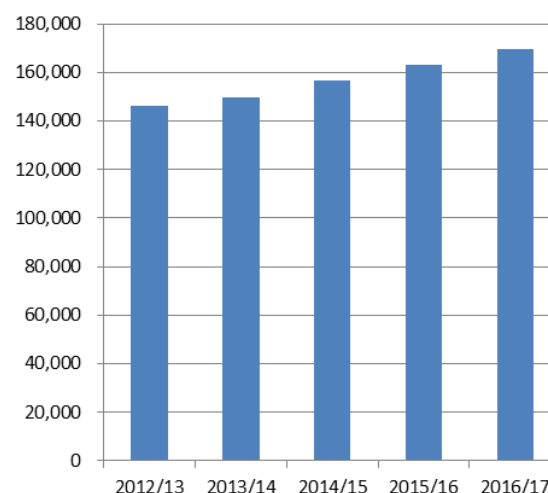


Chart 5: Expenditure £000s



### Activity Trends

Charts 1 to 3 show the growth in inpatient and day case activity over the five-year period, measured as completed patient spells, up by 4%, and a reduction in outpatient attendances by 6%.

The growth in inpatient and day case activity relates to increased activity purchased by clinical commissioning groups to achieve national waiting time targets. The majority of the activity growth over the period relates to an increase in non-elective admissions of 14%.

Emergency Department attendances are up 5% over the five-year period. This reflects the national challenges to NHS Emergency Departments across the country.

Total outpatients activity has reduced over the five-year period because antenatal and postnatal activity from 1<sup>st</sup> April 2013 is now recorded as part of the Maternity Pathway and no longer an Outpatient Attendance.

Chart 4 shows the growth in income over the five-year period from April 2012 to March 2017. This growth in income is at an average rate of 3% a year over the five-year period. In 2016/17, the increase in income is mainly as a result of the new Sustainability and Transformation Fund Income and the transfer of commissioning responsibility for the West Dorset Minor Injuries Units to the Trust.

Chart 5 shows the growth in expenditure over the five-year period. Expenditure has grown significantly at an average rate of 4% a year. This is primarily the result of inflationary costs, including changes to employers' social security costs, additional staff recruited to maintain safe staffing levels and the costs associated with the Minor Injuries Units referred to above.

## **Cash Flow and Balance Sheet**

The Trust ended the year with £4.4 million cash at bank, against a plan of £0.9 million. This was an improvement in cash of £3.5 million compared to plan, and an increase of £0.4 million during the year. The improvement in cash against plan is mainly due to a managed underspend in the capital programme of £2.0 million and movements in working capital of £1.5 million.

The Trust had planned capital expenditure of £6.2 million for the year, including planned capital donations of £0.4 million. The actual capital expenditure was £4.2 million, consisting of £3.8 million from NHS funded assets and £0.4 million from charitable funds.

The Trust's land and buildings were valued independently by Bilfinger GVA in March 2017, in line with accounting policies. The valuation resulted in positive and negative valuation movements.

Overall there was an increase in the valuation of land and buildings of £3.1 million. This included charges to the Revaluation Reserve of £1.8 million on land and credits of £4.9 million on buildings and dwellings. The changes in valuation are linked to the increases in the buildings index during 2016/17 and a comprehensive review of the estates carried out by our new valuer, Bilfinger GVA.

A small amount of previous year impairments were reversed and recognised in other operating expenses in the Consolidated Statement of Comprehensive Income, where in previous years there had been insufficient revaluation balances to offset impairments. Where the valuation included impairments in excess of the amount held for those assets in the revaluation reserve, the excess was charged to the Consolidated Statement of Comprehensive Income in the year.

## **Charitable Funding**

The Trust is fortunate to be supported by Dorset County Hospital Charity and a number of other local charities. All Dorset County Hospital Charity funds benefit the Trust. In 2016/17, the Trust received charitable grants for capital projects from the Charity of £0.3 million. This was the first instalment of funding for the new Cancer facilities at Dorset County Hospital and also received a grant of £0.1 million from the friends of Dorset County Hospital towards the establishment of a new procedure suite.

## **Capital Expenditure**

Capital expenditure during 2016/17 was focused on backlog maintenance, the provision of medical equipment and investment in IT projects. The Trust underspent on its planned capital programme of £6.2 million by £2.0 million. The Trust reduced expenditure during the year through a risk based approach to ensure continuity of patient care. The Trust's major developments were to set-up a procedure suite of £0.3 million, to start the redesign of the Catheter Laboratory service to include refurbishment of the current Laboratory and the introduction of a second Laboratory and continued investment in the Digital Patient Record of £1.1 million.

## Environmental Performance

The Trust remains committed to acting sustainably and minimising our environmental impact. The Trust has a Sustainable Development Strategy and a management plan which is reviewed and monitored by the Trust's Sustainability Working Group,. The Sustainability Report gives details of the key performance measures and our priorities and targets for the future.

## Social Community and Human Rights Issues

The Trust takes its responsibilities towards the community it serves very seriously and recognises the responsibility it has to:

- meet the acute health needs of the population it serves as safely, effectively and efficiently as possible
- ensure that services are designed and delivered taking into account the views and opinions of patients
- take into account the impact it has on the environment. As set out in the sustainability report, the Trust is committed to reducing its environmental impact
- take into account its status as a large employer and that decisions it makes may impact on the local economy and the health and wellbeing not only of staff but their families as well
- take into account its responsibility to respect human rights and to ensure that actions and decisions do not have an adverse impact on human rights
- ensure that staff feel motivated, empowered and are clear about the difference they are making to patient care and the achievement of the Trust's strategic objectives
- ensure that the Trust is a positive place to work.

The Human Rights Act is integrated into the Trust's day to day operations and implemented through policies, procedures and strategy. It is essential that staff and service users are aware of the specific requirements of the Act and its application in a human rights based approach to healthcare. The principles of Human Rights are integrated within the Trust training programme and communicated to patients via the Patient Charter.

## Events After the Reporting Period

There have not been any significant events requiring disclosure after the reporting period to the date of this report.

## Overseas Operations

The Trust has no overseas operations.

Patricia Miller  
Chief Executive  
22 May 2017

# Accountability Report

## Directors' Report

The Board of Directors comprises of the Chair, six Non-Executive Directors, six Executive Directors and one non-voting Executive Director. Full details of the Board can be found in the NHS Foundation Trust Code of Governance Disclosures section of the report.

The Trust maintains Registers of Interest for Directors and Governors which are available on application the Trust Secretary. The Trust can confirm that no Directors or Governors have any interest which conflict with their responsibilities.

The Directors can confirm that the Trust has complied with the cost allocation and charging guidance issues by HM Treasury.

The Directors can confirm that the Trust has not made any political and charitable donations.

The Trust has adopted the Better Payment Practice Code, which requires it to aim to pay all undisputed invoices by their due date, or within 30 days of receipt of goods or a valid invoice. The application of this policy resulted in a supplier payment period of 35 days for the Trust's trade payables as at 31 March 2017 (2016: 26 days). The Trust incurred interest and compensation charges of £160 during 2016/17 (£161 in 2015/16) under The Late Payment of Commercial Debt (interest) Act 1998. The performance of the Trust in complying with the Code was as follows:

	2016/17		2015/16	
	Number	Value £000	Number	Value £000
<b>Trade payables</b>				
Total bills paid in year	<b>48,901</b>	<b>73,345</b>	46,725	45,245
Total bills paid within target	<b>37,699</b>	<b>55,269</b>	44,016	40,947
Percentage of bills paid within target	<b>77%</b>	<b>75%</b>	94%	91%
<b>NHS payables</b>				
Total bills paid in year	<b>1,872</b>	<b>13,265</b>	2,084	16,042
Total bills paid within target	<b>1,399</b>	<b>10,330</b>	1,990	15,714
Percentage of bills paid within target	<b>75%</b>	<b>78%</b>	95%	98%

The Trust has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), by ensuring the income from the provision of goods and services for the purposes of the health service in England are greater than income from the provision of goods and services for any other purposes. The income from provision of goods and services for any other purpose was £939k which represents 0.55% of total Trust income. The Trust's financial planning ensures the requirement is maintained in the future and that any income for other purposes is contributing a profit for reinvestment into health services in England.

Delivery of the Trust's quality priorities are based on the principles of strategy, capability and culture, structures and measurement as describe in the Well Led Framework. Oversight of the Trust's service quality is undertaken by the Quality Committee which meets on a monthly basis. The Quality Committee is chaired by a Non-Executive Director. Both the minutes and a verbal update by the Chair of the committee are received by the Trust Board. Further detail on quality and quality governance are provided within the Quality Report, Performance Report and the Annual Governance Statement. There are no material inconsistencies between the Annual Governance Statement, the Quality Report and the Care Quality Commission Report.

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

The Directors are required to, and accept responsibility for, preparing the annual report and accounts for each financial year. The Directors consider that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust performance, business model and strategy.

## Remuneration Report

### Annual Statement on Remuneration

As Chairman of the Remuneration and Terms of Service Committee, I am pleased to present the Remuneration Report for 2016/17.

The NHS Foundation Trust Code of Governance and NHS policy required that remuneration committees ensure levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully but to avoid paying more than is necessary for this purpose. In order to fulfil these requirements, Executive Director salaries are nationally benchmarked against similar trusts and this benchmarking information is used to inform the deliberations and decisions of the Remuneration and Terms of Service Committee.

For 2016/17 the Committee decided not to apply any across the board cost of living increase to executive salaries. It agreed, however, to increase the remuneration of the Director of Organisational Development and Workforce to bring this in line with levels at similar trusts. The Committee decided that all other Executive Director salaries were benchmarked appropriately.

Mark Addison  
Remuneration and Terms of Service Committee Chair  
22 May 2017



## Senior Managers Remuneration Policy

### Policy on Remuneration of Senior Managers

The Trust's senior management remuneration policy requires the use of benchmark information and the Trust makes reference to the Foundation Trust Network Annual Salary Comparison Report.

With the exception of Executive Directors, the remuneration of all staff is set nationally in accordance with NHS Agenda for Change (for non-medical staff) or Pay and Conditions of Service for Doctors and Dentists. Performance Related Pay is not applicable for any Trust staff, including Executive Directors. Future policy on senior manager remuneration will remain in line with national terms and conditions.

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by either party with three months' notice, or six months' notice in the case of the Chief Executive. The Trust's normal disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

The total remuneration for each of the Trust's Executive Directors comprises the following elements:

Salary + Pension and Benefits = Total remuneration

### Future Policy Table

The Trust's remuneration policy in respect of each of the above elements is outlined in the tables below.

#### Salary – (Fees and Salary)

##### Purpose and Link to Strategy

- Helps to recruit, reward and retain
- Reflects competitive market level, role, skills, experience and individual contribution

##### Operation

Base salaries are set to provide the appropriate rate of remuneration for the job, taking into account relevant recruitment markets, business sectors and geographical regions.

The Remuneration Committee considers the following parameters when reviewing base salary levels:

- Pay increases for other employees across the Trust
- Economic conditions and governance

##### Opportunity

The Remuneration Committee ensures levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully but avoid paying more than is necessary though using benchmarking.

Current benchmarking data was reviewed by the Remuneration Committee and it was agreed to increase remuneration of Executive Managers to bring in line with peer organisations.

##### Performance Conditions

None, although performance of both the Trust and the individual are taken into account when determining whether there is a base salary increase each year. The individual

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>trends</li> <li>• The individual's performance, skill and responsibilities through appraisals</li> <li>• Base Salaries at NHS organisations of similar size are benchmarked against Dorset County Hospital NHS Foundation Trust</li> <li>• Base Salaries are paid in 12 equal monthly instalments via the regular monthly employee payroll</li> <li>• The Executive Directors do not receive performance related pay.</li> </ul> | <p>receives an annual appraisal to review performance and set objectives.</p> <p><b>Performance Period</b></p> <p>Annual Appraisal covers a 12 month period</p> |
|---|---|

## Pension and Benefits

### Purpose and Link to Strategy

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Help to recruit and retain</li> <li>• NHS Pension scheme arrangements provide a competitive level of retirement income</li> </ul> | <p>The principal features and benefits of the NHS Pension Scheme are set out in a table in the Remuneration Report.</p> |
|--|---|

### Operation

Executive Directors are eligible to receive pension and benefits in line with the policy for other employees.

Pension related benefit is the annual increase in pension entitlement accrued during the current financial year from total NHS career service.

Pension arrangements are in accordance with the NHS Pension Scheme. There is no cash alternative

### Opportunity

The maximum Employers' contribution to NHS Pension Scheme is 14.3% of base salary for all employees including Executive Directors.

Executive Directors are entitled to join the NHS Pension Scheme, which from April 2015 is a Career Average Revalued Earnings scheme.

### Performance Conditions

None

Where an individual is a member of a legacy NHS defined benefit pension scheme section (1995 or 2008) and is subsequently appointed to the Board, he or she retain the benefits accrued from these schemes.

### Performance Period

None

## Differences in Remuneration Policy for Other Employees

The remuneration approach for Executive Directors is consistent with The UK Corporate Governance Code, NHS Foundation Trust Code of Governance and NHS Policy. This guidance requires that remuneration committees ensure levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully.

The structure of the reward package for the wider employee population is based on the national NHS remuneration frameworks for Medical, Dental and Non-Medical Staff. Non-Medical Staff remuneration is in line with Agenda for Change Framework, which assesses roles and on-going performance on the Key Skills Framework. Medical and Dental staff remuneration is in line with the framework for Medical and Dental Staff remuneration. All staff are eligible to join and participate in the NHS Pension Scheme.

Where one or more senior managers are paid more than £142,500, the committee is required to ensure this remuneration is reasonable. The Trust has one senior manager paid more than £142,500. The committee is satisfied the salary of this individual is reasonable when compared to the benchmarking provided in setting the senior managers' salaries.

### Policy on Remuneration of Non-Executive Directors

Element	Purpose and link to strategy	Overview
Fees	To provide an inclusive flat rate fee that is competitive with those paid by other NHS organisations of equivalent size and complexity	The remuneration and expenses for the Trust Chairman and Non-Executives are determined by the Council of Governors.
Appointment		The Council of Governors appoint the Non-Executive Directors in accordance with the Trust's constitution which allows them to serve two three year terms. Any term beyond six years is subject to rigorous review, and takes into account the need for progressive refreshing of the board and their independence. This is subject to annual re-appointment approved by the Council of Governors.

## Annual Report on Remuneration

The following sections of the Remuneration Report are not subject to audit

### Remuneration and Terms of Service Committee

Remuneration and Terms of Service for the Chief Executive and Executive Directors is considered by a Remuneration and Terms of Service Committee consisting of the Chair and Non-Executive Directors. During 2016/17, the Committee met to review Executive Directors' Remuneration, the Very Senior Manager Reward Policy and Clinical Excellence Rewards.

The Trust's Director of Organisational Development and Workforce, Mark Warner and the Trust's Chief Executive, Patricia Miller attended where appropriate to provide benchmarking information and advice.

The Committee's attendance record is set out in the table below:

Name	Attendance/Meetings eligible to attend
Mr M Addison (Trust Chair) (Chair)	3/3
Dr M Earwicker (Vice Chair)	1/1
Mr M Rose (Non-Executive Director)	2/3
Mr G Stanley (Non-Executive Director)	2/3
Mr P Greensmith (Non-Executive Director)	3/3
Prof J Reid	0/1
Prof S Atkinson	1/2
Ms V Hodges	2/2
Ms J Gillow	1/2

### Senior Manager Service Contracts

The table below contains contract information on the Trust's Senior Managers for the financial year 2016/17.

Name	Title	Current Tenure	Notice Period
<b>Non- Executive Directors</b>			
Mr Mark Addison	Chair	24/03/16 – 23/03/19	3 months
Mr Peter Greensmith	NED, Vice Chair from 1/10/16	01/06/14 – 31/05/17	3 months
Mr Graeme Stanley	NED, Senior Independent Director	01/10/16 – 30/09/19	3 months
Mr Matthew Rose	NED	17/06/14 – 16/06/17	3 months
Ms Victoria Hodges	NED	01/09/16 – 31/08/19	3 months
Ms Judy Gillow	NED	01/09/16 – 31/08/19	3 months
Prof Sue Atkinson	NED	01/09/16 – 31/08/19	3 months

## DCHFT Annual Report and Accounts 2016/17

Dr Martin Earwicker	NED, Vice Chair until 30/9/16	01/10/13 – 30/09/16 (left 30/09/16)	3 months
Professor Jane Reid	NED	1/11/13 – 31/10/16 (left 31/08/16)	3 months
<b>Executive Directors</b>			
Ms Patricia Miller	Chief Executive	Commenced 15/09/14	6 months
Ms Libby Walters	Director of Finance and Resources	Commenced 12/09/12	3 months
Mr Paul Lear	Medical Director	Commenced 01/10/11	3 months
Ms Julie Pearce	Chief Operating Officer (Interim Director of Nursing and Quality)	Commenced 26/05/15  From 04/01/16 to 31/08/16)	3 months
Mr Mark Warner	Director of Organisational Development and Workforce	Commenced 02/03/15	3 months
Ms Nicky Lucey	Director of Nursing and Quality	Commenced 01/09/16	3 months
Mr Nick Johnson	Director of Strategy and Business Development	Commenced 01/02/16	3 months
Ms Alison Tong	Director of Nursing and Quality	On secondment (left 01/08/16)	

### Expenses of Governors and Directors

The expenses incurred or reimbursed by the Trust relating to Governors and Directors were:

	2016/17 Number receiving expenses / total	£	2015/16 Number Receiving Expenses / total	£
Governors	8 / 32	1,127	6 / 32	1,285
Chairman and non-executive directors	6 / 8	4,271	5 / 7	4,711
Executive directors	8 / 8	11,993	8 / 9	6,981
Total expenses		17,391		12,977

**The following sections of the Remuneration Report are subject to audit**

The total remuneration of directors and senior managers for 2016/17 was £802,700 (2015/16: £713,800 which includes £41,400 of interim director agency fees).

<b>Remuneration of Directors - 2016/17</b>	<b>Fees and salary (Bands of £5,000) £ 000s</b>	<b>Taxable benefits (nearest £100)</b>	<b>Pension related benefits (Bands of £2,500) £ 000s</b>	<b>2016/17 Total (Bands of £5,000) £ 000s</b>
<b>Chairman</b>				
Mr M Addison	40 – 45	-	-	<b>40 – 45</b>
<b>Non-executive Directors</b>				
Prof M Earwicker <sup>1</sup>	5 – 10	-	-	<b>5 – 10</b>
Mr P Greensmith	10 – 15	-	-	<b>10 – 15</b>
Ms J Gillow <sup>2</sup>	5 – 10	-	-	<b>5 – 10</b>
Prof J Reid <sup>3</sup>	5 – 10	-	-	<b>5 – 10</b>
Prof S Atkinson <sup>4</sup>	5 – 10	-	-	<b>5 – 10</b>
Ms V Hodges <sup>5</sup>	5 – 10	-	-	<b>5 – 10</b>
Mr M Rose	10 – 15	-	-	<b>10 – 15</b>
Mr G Stanley	10 – 15	-	-	<b>10 – 15</b>
<b>Executive Directors</b>				
Ms P Miller, Chief Executive	155 – 160	-	42.5 - 45	<b>200 – 205</b>
Mr P Lear, Medical Director	80 – 85	-	-	<b>80 – 85</b>
Ms N Lucey, Director of Nursing & Quality <sup>6</sup>	65 – 70	-	32.5 – 35	<b>100 – 105</b>
Ms J Pearce, Chief Operating Officer and Interim Director of Nursing and Quality <sup>7</sup>	115 – 120	-	0 – 2.5	<b>120 – 125</b>
Ms C A Tong, Director of Nursing & Quality <sup>8</sup>	40 – 45	-	20 – 22.5	<b>60 – 65</b>
Mr M Warner, Director of Organisational Development and Workforce	110 – 115	-	35 – 37.5	<b>145 – 150</b>
Ms L Walters, Director of Finance & Resources	110 – 115	-	45 – 47.5	<b>155 – 160</b>
Mr N Johnson, Director of Strategy and Business Development	100 – 105	-	-	<b>100 – 105</b>

Remuneration of Directors - 2015/16	Fees and salary (Bands of £5,000) £ 000s	Taxable benefits (nearest £100) £ 000s	Pension related benefits (Bands of £2,500) £ 000s	2015/16 Total (Bands of £5,000) £ 000s
<b>Chairman</b>				
Dr J Ellwood <sup>9</sup>	40 – 45	-	-	40 – 45
Mr M Addison <sup>10</sup>	0 – 5	-	-	0 – 5
<b>Non-executive Directors</b>				
Prof M Earwicker	15 – 20	-	-	15 – 20
Mr P Greensmith	10 – 15	-	-	10 – 15
Ms T Peters <sup>11</sup>	5 – 10	-	-	5 – 10
Prof J Reid	10 – 15	-	-	10 – 15
Mr M Rose	10 – 15	-	-	10 – 15
Mr G Stanley	10 – 15	-	-	10 – 15
<b>Executive Directors</b>				
Ms P Miller, Chief Executive	155 – 160	-	92.5 - 95	250 – 255
Mr P Lear, Medical Director	70 – 75	-	-	70 – 75
Ms R King, Acting Director of Finance <sup>12</sup>	5 – 10	-	20 – 22.5	25 – 30
Mr R McEwan, Interim Chief Operating Officer <sup>13</sup>	40 – 45	-	-	40 – 45
Ms J Pearce, Chief Operating Officer and Interim Director of Nursing and Quality <sup>14, 15</sup>	100 – 105	-	-	100 – 105
Ms C A Tong, Director of Nursing & Quality <sup>16</sup>	95 – 100	-	17.5 – 20	110 – 115
Mr M Warner, Director of Organisational Development and Workforce	105 – 110	-	12.5 - 15	120 – 125
Ms L Walters, Director of Finance & Resources	105 – 110	-	47.5 - 50	155 – 160
Mr N Johnson, Director of Strategy and Business Development <sup>17</sup>	15 – 20	-	-	15 – 20

1 – Resigned on 30 September 2016

2 – Appointed on 1 September 2016

3 – Resigned on 31 August 2016

4 – Appointed on 1 September 2016

5 – Appointed on 1 September 2016

6 – Appointed on 1 September 2016

7 – Acting until 30 August 2016

8 – Resigned on 1 August 2016

9 – Resigned on 25 March 2016

10 – Appointed on 23 March 2016

11 – Resigned on 31 October 2015

12 – Acting finished on 20 April 2015

13 – Resigned on 29 May 2015

14 – Appointed on 26 May 2015

15 – Acting from 4 January 2016

16 – Seconded from 4 January 2016

17 – Appointed on 1 February 2016

There were no annual performance related or long term performance related bonuses paid during the year 2016/17 or 2015/16.

There have been no payments during 2016/17 to individuals who were senior managers in the current or in a previous financial year for loss of office.

There have been no payments to past senior managers during 2016/17.

### **Fair Pay Multiple Statement**

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director of the Trust and the median remuneration of the Trust's workforce.

The banded remuneration of the highest-paid director in the Trust in financial year 2016/17 was £155,001 to £160,000 (2015/16: £155,001 to £160,000). This was 5.99 times (2015/16: 6.29 times) the median remuneration of the workforce, which was £26,302 (2015/16: £25,047).

In 2016/17, 9 (2015/16: 9) employees received remuneration in excess of the highest paid director. Remuneration ranged from £160,000 to £195,000 (2015/16: £158,000 to £276,000).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions or the cash equivalent transfer value of pensions. The median remuneration of the workforce is the total remuneration of the staff member lying in the middle of the linear distribution of the total staff in the Trust, excluding the highest paid director. This is based on an annualised full time equivalent remuneration as at the reporting period date.

The multiple for 2016/17 has decreased due to the change in the median remuneration which is due to the national pay award of 1% and an increase in spine point within the Band 5 salary range.

The median remuneration of the workforce in both 2016/17 and 2015/16 falls within the salary range of a Band 5 position under the Agenda for Change terms and conditions that apply to all non-medical staff. The actual salary of staff within each band is dependent on a number of factors, the most significant being the number of years they have served in that position.

All employees receiving remuneration in excess of the highest paid director were medical consultants.

### **Pension Arrangements**

All executive directors of the Trust are eligible to join the NHS Pension Scheme. The Chairman and non-executive directors are not eligible to join the scheme and are not accruing any retirement benefits in respect of their services to the Trust. The Trust did not make any contributions to any other pension arrangements for directors and senior managers during the year.



The principal features and benefits of the NHS Pension Scheme are set out in the table below.

	1995 section	2008 section	2015 section
Member contributions	5% - 13.3% depending on rate of pensionable pay		
Pension	A pension worth 1/80th of final year's pensionable pay per year of membership	A pension worth 1/60th of reckonable pay per year of membership	A pension worth 1/54 <sup>th</sup> of Career Average Re-valued Earnings of pensionable pay per year of membership
Retirement lump sum	3 x pension. Option to exchange part of pension for more cash up to 25% of capital value	Option to exchange part of pension for cash at retirement, up to 25% of capital value. Some members may have a compulsory amount of lump sum	Option to exchange part of pension for a lump sum up to 25% of capital value
Normal retirement age	60	65	Equal to an individuals' State Pension Age or age 65 if that is later
Death in membership lump sum	2 x final years' pensionable pay (actual pensionable pay for part-time workers)	2 x reckonable pay (actual reckonable pay for part-time workers)	The higher of (2 x the relevant earnings in the last 12 months of pensionable service) or (2 x the revalued pensionable earnings for the Scheme year up to 10 years earlier with the highest revalued pensionable earnings)
Pensionable pay	Normal pay and certain regular allowances		

The tables below set out details of the retirement benefits that executive directors have accrued as members of the NHS Pension Scheme. All of the executive directors that are accruing benefits under these Schemes with their normal retirement age in line with the table above.

	Real Increase / (decrease) in pension at retirement (bands of £2,500) £000	Real Increase / (decrease) in lump sum at retirement (bands of £2,500) £000	Total accrued pension at retirement at 31/03/2017 (bands of £5,000) £000	Related lump sum at retirement at 31/03/2017 (bands of £5,000) £000
Ms P Miller, Chief Executive	2.5 - 5.0	0 - 2.5	30 – 35	80 – 85
Ms CA Tong, Director of Nursing & Quality	0 - 2.5	0 – 2.5	35 – 40	105 – 110
Mr M Warner Director of Organisational Development and Workforce	2.5 – 5.0	0 – 2.5	15 – 20	0 – 2.5
Ms J Pearce, Chief Operating Officer and Interim Director of Nursing and Quality	0 - 2.5	2.5 - 5	50 – 55	155 – 160
Ms L Walters, Director of Finance & Resources	2.5 – 5.0	2.5 – 5.0	35 - 40	90 – 95
Ms N Lucey, Director of Nursing & Quality	0 - 2.5	2.5 - 5	40 – 45	130 – 135

	Cash Equivalent Transfer Value at 31/03/2017 £000	Cash Equivalent Transfer Value at 01/04/2016 £000	Real increase in Cash Equivalent Transfer Value £000
Ms P Miller, Chief Executive	546	495	51
Ms CA Tong, Director of Nursing & Quality	720	677	15
Mr M Warner Director of Organisational Development and Workforce	190	156	34
Ms J Pearce, Chief Operating Officer and Interim Director of Nursing and Quality	1175	1124	51
Ms L Walters, Director of Finance & Resources	505	459	46
Ms N Lucey, Director of Nursing & Quality	731	680	30

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. CETVs are not disclosed for scheme members who have reached their normal retirement date.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the NHS Pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

The real increase in CETV represents the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the year.

Patricia Miller  
Chief Executive  
22 May 2017

## Staff Report

### Valuing Our Staff

As a major local employer of 2,700 staff, who fulfil a wide range of professional and multidisciplinary roles, we recognise that our workforce defines who we are and how we are viewed by the patients and carers we serve. We strive to ensure our staff are highly skilled and well supported in their working environment, in order that they are able to deliver the highest standards of compassionate and safe care. Investment in the recruitment, education, training, support and well-being of our staff is an important consideration for us.

### Recruitment

A sharp rise in retirements has meant that recruitment for key clinical posts including Medical, Nursing and Allied Health Professionals remained challenging in 2016. The Trust increased its UK nurse recruitment through the appointment of a Nurse Lead for Bank, Relief Pool and Recruitment. Further benefits were realised from the completed roll-out of the TRAC recruitment software resulting in a reduced time to hire. Advertising response has been augmented through automated posting of vacancies through social media channels. These investments will support the ongoing events and advertising program.

### Employment Policies

The Trust has in excess of 70 employment policies in place which have been designed to provide guidance to our staff and to ensure we meet our legal obligations to them. The effectiveness of each policy is reviewed in conjunction with staff representatives every three years as a minimum, but most are reviewed more frequently due to changes to employment law or best practice or in response to feedback from staff. During 2016, 30 of our employment policies were reviewed to ensure effectiveness and adherence to legal requirements.

### Appraisal Process

After a successful trial, a new appraisal process for non-medical staff was launched in October 2016. The aim of the process review was to incorporate the Trust Values, whilst increasing self-appraisal, achieving a greater emphasis on objectives, and retaining a formal assessment linked to pay. The feedback from a broad range of staff groups following the launch of the new process has been overwhelmingly positive and work has now begun on introducing a similar values based process for the medical workforce.

**Staff Gender Analysis (as at 31 March 2017)**

At 31 March 2017	
Board directors by gender	
Male	6
Female	7
Employee headcount by gender (full-time equivalent basis)	
Male	539
Female	1,734
Total	2,273

**Staff Sickness**

The staff sickness information contained in the table below has been calculated and supplied by the Department of Health. The information has been calculated on a calendar year basis.

	2015	2016
Total days lost	17,836	17,666
Total staff employed (Full-time equivalent basis)	2,236	2,267
Average working days lost per employee	8.0	7.8

**Equality and Diversity**

The Trust is committed to ensuring that people do not experience inequality through discrimination or disadvantage either in the health care they receive or as members of staff in their employment with the Trust. In this context, our Equality Policy defines the approach that we take to promoting and championing a culture of diversity and equality of opportunity, access, dignity, respect and fairness in the services we provide and in our employment practices. The policy also sets out our commitment to compliance with relevant equality legislation and the NHS Equality Delivery System 2 (EDS2) to support the delivery of its commitment to equality. In accordance with our legal obligations, we collate staff data and this forms part of an annual Equality and Diversity and Workforce Race Equality Standard Reports on compliance to the Trust Board. This information is also published on our website and through this analysis we are able to identify good practice and areas for improvement.

In 2016, we were pleased to gain the Disability Confident accreditation, which replaces the 'Two Ticks' symbol guaranteeing an interview for any disabled person who meets the

minimum criteria for a role. Disability Confident status is awarded by Job Centre Plus to employers and signifies our positive attitude towards employing and retaining disabled staff and developing their abilities. The Trust policies aim to help prospective and current employees who may become disabled with a range of reasonable adjustments that enable them to return to and remain in work. Equality Impact Assessments (EIAs) are carried out on all proposed policies, service developments or functions to identify any adverse or positive effect on differing groups within the Trust and the local community. The Trust provides on-going skills training in Equality and Diversity to all staff; this covers steps that the Trust and staff must take in order to promote equality of opportunity for staff and patients across all protected characteristics. The Trust seeks to encourage all of our staff to value the possibilities in each other and explore the opportunities that difference brings. During 2016 we established an Equality & Diversity Steering Board to oversee this important agenda.

### **Consultation, Partnership Working and Staff Engagement**

We have a number of established mechanisms of communicating information across the Trust, including a weekly email bulletin, a weekly email briefing from the Chief Executive, monthly team briefing sessions and a quarterly staff magazine. The Trust also communicates stories of interest via social and local media.

Our established consulting and negotiating bodies, the Partnership Forum (for non-medical staff) and Local Negotiating Committee (for medical staff), continue to make an important contribution to promoting effective staff engagement and partnership working and in ensuring these are underpinned by a commitment to: promoting the success of the organisation; recognising the respective parties' legitimate interests; operating in an honest and transparent manner; focusing on the quality of working life and its benefit to the quality of patient care; maintaining, as far as possible, employment security. The Trust also takes part in the national staff survey annually and a quarterly local staff survey.

As part of our People Strategy which was launched in 2015 we undertook a large-scale project to refresh and launch the staff values. Staff were encouraged to participate in the creation of the values through a series of workshops and the final version is below. In 2016 we have developed this work further, embedding our values into our systems and procedures, including values based appraisal and values based induction.



### **Health and Wellbeing**

All our staff have access to occupational health and wellbeing services provided by our partner organisation, Dorset Healthcare University Foundation NHS Trust. Providing proactive and preventative support, the service undertakes health checks, vaccinations and immunisation programmes besides dealing with work related issues such as needlestick injuries. Advice and support are offered to employees and managers in relation to the

rehabilitation of staff returning to work following illness or with a known disability. Staff also have access to confidential counselling via the department and can self-refer themselves for fast track physiotherapy treatment for joint or muscle pain.

Staff are encouraged to take a proactive approach to their wellbeing. The Trust's LightenUp in-house wellbeing programme continued this year and feedback from staff continues to be very positive, with the programme helping delegates to combat stress at work and in their personal lives. During the latter part of the year, the Trust took part in the seasonal flu campaign, aiming to vaccinate as many frontline staff as possible against the influenza virus in order to protect patients, visitors to the hospital, staff and their families. 58% of staff received the vaccine at work, a significant improvement on last year's uptake rate.

### **Health and Safety**

Health, safety and security are managed in the Trust according to risk management principles as set out in the HSE publication "Successful Health and Safety Management" (HSG65).

The health, safety and security key achievements during 2016/2017 were;

- Reduction in the number of slip, trip and falls.
- Reduction in the number of accidents
- Reduction in the number of violence and aggression incidents
- Full review of all security policies and procedures

The Trust logged 174 workplace incidents during 2016/17. The total number of incidents reported to Health and Safety Executive under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) is 10. These comprise mainly of over-seven-day absences following an incident, with a small number of fracture incidents. There have been no notifiable dangerous occurrences within the year. A total of 164 incidents were logged which were not reportable to the Health and Safety Executive. The majority of these related to slip trip and fall incidents. Each incident is overseen by the Health, Safety & Security Manager and where appropriate a Root Cause Analysis investigation is carried out.

The Trust provided training courses to its staff to promote health and safety in the workplace and ensure the workforce stays current with regulations, these courses included General Risk Assessors, Control of Substances Hazardous to Health (COSHH) assessor, Risk Management/Health and Safety, Conflict Resolution Training, Risk Assessor, level 1 Health and Safety course, Human Factors Training, Fire Training, Moving and Handling, including Slips, Trip and Falls, Raise Awareness of Prevent (terrorism) and Lone Worker familiarisation.

### **Countering Fraud and Corruption**

The Trust's Counter Fraud Policy sets out the standards of honesty and propriety expected of staff and encourages employees to report any suspicious activity that might indicate fraud

or corruption promptly. The policy links to the Trust's Whistleblowing and Disciplinary policies and various NHS publications on this subject.

The Trust has a counter fraud service provided by TIAA who report directly to the Director of Finance and Resources and also report regularly to the Audit Committee throughout the year.

Raising awareness of the need to counter fraud and corruption is taken seriously by the Trust and is communicated via a variety of methods, including leaflets, counter fraud newsletters and notices, staff bulletins, staff awareness presentations, induction training and the Trust's intranet.

### What our Staff Say

Annually, we participate in the NHS national staff survey. In 2016 we surveyed all our staff and were in the best 20% of acute trusts for our response rate. The Trust's overall score for staff engagement (measured on a scale of 1 to 5, where five is the best score) was 3.80, which was in line with the national average of 3.81 for Acute Trusts.

Overall the results show a relatively good overall picture with most findings in line with national norms. The latest results show that no significant changes have been made across any of the 32 key findings, showing sustained levels of staff engagement. Results show high consistency with acute national averages. Whilst this is encouraging, it is clear that key areas require further development and we will continue to work with staff representatives to address concerns raised through staff surveys held at national and local level with the aim of improving the working lives of staff.

The response rate to the staff survey and highest and lowest ranking scores were as follows:

	2015/16		2016/17		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Response Rate	57%	41%	54%	44%	3% deterioration



Top 5 Ranking Scores	2015/16		2016/17		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion  (higher = better)	91%	87%	91%	87%	No change
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month  (lower = better)	29%	31%	29%	31%	No change
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months  (lower = better)	28%	28%	25%	27%	3% improvement
Percentage of staff working extra hours  (lower = better)	72%	72%	70%	72%	2% improvement
Percentage of staff experiencing physical violence from staff in last 12 months  (lower = better)	3%	2%	2%	2%	1% improvement

Bottom 5 Ranking Scores	2015/16		2016/17		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Staff confidence and security in reporting unsafe clinical practice (higher = better)	3.58/5	3.62/5	3.58/5	3.65/5	No change
Percentage of staff satisfied with the opportunities for flexible working patterns (higher = better)	45%	49%	47%	51%	2% improvement
Staff motivation at work (higher = better)	3.91/5	3.94/5	3.88/5	3.94/5	0.03 deterioration
Quality of non-mandatory training, learning or development (higher = better)	4.03/5	4.03/5	4.01/5	4.05/5	0.02 deterioration
Percentage of staff attending work in the last 3 months despite feeling unwell  because they felt pressure from their manager, colleagues or themselves  (lower = better)	63%	59%	61%	56%	2% improvement
The Trust also gauges staff responses in each quarter as to whether they would recommend the Trust to family or friends as a place to work. In quarters 1, 2 and 4 this information is gathered via the staff friends and family test (Staff FFT); in quarter 3 this test forms part of the national staff survey.					
Staff Survey feedback – staff who would recommend the Trust as a place to work to family or friends			2014	2015	2016
Dorset County Hospital			61%	63%	65%
National Average			58%	59%	59%

Staff FFT feedback – staff who would recommend the Trust as a place to work to family or friends	Quarter 1	Quarter 2	Quarter 4
Dorset County Hospital	54%	55%	
National Average	63%	64%	

The Trust has taken a number of actions to improve staff satisfaction and in turn the quality of its services. Actions taken in 2016 in response to staff feedback include a review of the appraisals, leadership development training for staff and the development of a number of initiatives focusing on staff wellbeing.

### Celebrating Success

Every day, individuals and teams within the Trust go above and beyond the call of duty. Our annual GEM (Going the Extra Mile) Awards have become a well-established means of recognising and honouring staff and volunteers for their service and outstanding contribution to the care of patients and running of the hospital. Staff, patients, their relatives, members of the public and volunteers took the opportunity of nominating those individuals who they judged met the criteria for each of the Trust's nine award categories and best exemplified our values. The hard work and dedication of the nominees were celebrated at a presentation ceremony held in July at Kingston Maurwood College. The event was hosted by the Chairman, Mark Addison and Patricia Miller, Chief Executive, who personally congratulated staff on their achievements. This year's winners were:

Chairman's Award	Mairead Farrell
Innovation Award	Ross Cumber
Leadership Award	Ian Mew
Lifetime Achievement Award	Nesta Dunbar
Patient Choice Award	Sarah Burgess
Patient Safety Award	Diabetes Team
Student/Apprentice of the Year Award	Lois Tattershall
Team of the Year Award	Sterile Services Team
Volunteer Award	Linda Hayward

In 2016, we also continued our WOW! Award scheme, a national employee recognition scheme external to the NHS, which aims to raise customer care standards in order that patients and visitors receive the best possible service and care. WOW! Awards give everyone the opportunity of saying 'thank you' and help us to provide patients and visitors with an even better experience by recognising those occasions when staff have delivered

excellent service. Staff can also nominate their colleagues if they think the service that they have received from them has been outstanding. Nominations are reviewed monthly by the WOW! Awards team and signed certificates, endorsed with the wording of the nomination, are presented by a member of the Executive Team.

### **Volunteering**

Volunteering continues to complement the work of the Trust and to provide much valued assistance and support to staff, patients and visitors alike. Volunteers come from all walks of life and range from those with extensive and diverse work and life skills to young people considering a career in the NHS. Anyone aged 16 or over who has some time to spare, and who can offer a regular commitment, is welcome to apply to be a Hospital volunteer.

The Trust employs a part-time Volunteer Workforce Co-ordinator within Recruitment, who supports the volunteer leads for individual wards and departments. Volunteering opportunities include placements on elderly care wards, which encourage interaction with patients and provide assistance at mealtimes, while other opportunities exist with the Hospital Guides, Friends of DCH, Ridgeway Radio and the Chaplaincy Service.

Potential volunteers considering joining the Trust can contact Abigail via [Abigail.Harris@dchft.nhs.uk](mailto:Abigail.Harris@dchft.nhs.uk).

### **Education, Learning and Development**

We are committed to developing the capability and skills of our multi-professional workforce to enable staff to deliver high quality, safe patient care. The implementation of our Education, Learning and Development Strategy supports this commitment.

The Trust's Education Centre offers a wide range of education, learning and development opportunities, not only for our staff, but also for the wider healthcare community and is constantly developing new and innovative ways of delivering ongoing learning. An annual training needs analysis is conducted each year to ensure that the resources of the Centre are targeted to areas that will directly benefit patients.

Essential Skills Training is the term we use to describe training we must provide by regulation and statute. This year, following a review of the provision of this training, we have seen an increase in levels of compliance and have been successful in reducing the amount of time staff need to take out of the workplace to maintain competence through greater use of eLearning packages.

The Care Certificate has been running for two years now. After values based recruitment, the Care Certificate continues this theme with evidence that staff are being inducted with quality skills and confidence given by the completion of the 15 standards set out in the Care Certificate. This is supported by the positive feedback from line managers and peer reviews/feedback.

These qualities benefit not only the staff but patients and their carers knowing the Trust's values are not only met but demonstrated, producing person-centred, supportive and compassionate staff. The Care Quality Commission had given impressive feedback regarding the depth and quality of the Care Certificate and we are considered a leading

example within Wessex. We have streamlined the Care Certificate to optimise the quality and dovetail straight into the Apprenticeship pathways. We are continuing to achieve 98 – 100 % completion within the set targets. This is now given recognition to the first step of the Healthcare Support Worker career progression pathway.

### **Leadership Development**

During 2016 we launched an ambitious Leadership Development Programme for 400 of the Trust's senior leaders. The programme was an important element of our People Strategy delivery plan, and was designed to equip our leaders with skills and knowledge required to achieve our goals. Through an inclusive, multi-disciplinary approach, we were able to raise the levels of leadership knowledge around organisational context and system working; developing a collaborative approach to leadership and embedding a culture of continuous quality improvement. Feedback for the programme was excellent, and the programme will be followed up during 2017/18 with a leadership programme for all other team leaders within the Trust.

### **Apprenticeships**

Investment continues regarding the Apprenticeships level 2-5 for bands 1-4 and undergraduate courses are continuing in areas including Nursing, Medical, Radiography, Pharmacy, Support Services, Healthcare Sciences and Administration. During 2016 nine new apprenticeships were introduced within the Trust and more are in the pipeline. In conjunction with Health Education Wessex, during 2016 the Foundation Degree course was introduced in two areas with positive results.

### **Bridging Programme & Maths & English Qualifications**

We continue to offer the Bridging Programme which assists Healthcare Support Workers to progress towards a trained nursing career using the Kings Fund workforce initiative. During 2016 two successful learners commenced Adult Nursing courses and another learner commenced the Bridging Programme in order to obtain a university place. We offer free Literacy and Numeracy courses for all staff wishing to improve and progress at work.

### **Medical Training**

In a recent Foundation Quality Visit, feedback from our Foundation Doctors highlighted a supportive culture in the Trust as demonstrated by high standard of education and friendly, helpful, approachable senior medical and nursing staff, resulting in a happy cohort of Foundation Doctors with a strong sense of identification with the Trust. The Education Centre continues to run the 'Introduction to Medicine' two day courses for students from local school who are interested in a career in medicine; many of whom went on to attend a 2 day work experience programme at the Trust. 2017 will see a similar 'Introduction to Nursing' course taking place.

## Library

Trust staff and students on placement benefit from the professional on-site library service which offers access to a wide range of print and electronic information resources and expert library staff. The service belongs to the large Thames Valley and Wessex NHS library network. The library also provides support to staff with e-learning queries.

## Consultancy

The NHS has additional controls for spending on consultancy contracts over the value of £50,000 to ensure value for money. The Trust had no contracts which exceeded the £50,000 limit. The table below shows the consultancy costs breakdown by category. These figures include £96k of costs linked to the local Vanguard project with Poole and Bournemouth.

	2016/17 £000s
Finance	73
Human Resources	10
Procurement	47
Property and Construction	7
Strategy	163
Information Technology	25
Organisation & Change Management	24
Strategy	13
Programme and Project Management	3
<b>Total</b>	<b>365</b>

## Reporting High Paid Off-payroll Arrangements

The Trust has a policy on the engagement of staff off-payroll to ensure compliance with employment law, tax law and HM Treasury guidance for government bodies. This contains a procedure to ensure appointees give assurances to the Trust that they are meeting their Income tax and National Insurance obligations.

The policy includes controls for highly paid staff including board members and senior officials, individuals under these sections require Accounting Officer approval and should only last longer than six months in exceptional circumstances.

For any off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months	Number of engagements
Number of existing engagements as of 31 March 2017	Nil

The Trust can confirm that we had no existing off-payroll engagements that had lasted for longer than six months as of the 31 March 2017.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months	Number of engagements
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	5
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	5
Number for whom assurance has been requested	5
Of which	
Number for whom assurance has been received	5

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	Nil
Number of individuals that have been deemed “board members and/or senior officials with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	17

The Trust has made no payments for off payroll arrangements to individuals through their own companies during 2016/17.

The following sections of the Staff Report are subject to audit

# **Average number of employees (WTE basis)**

	Average for year ended 31 March 2017		
	Total number	Permanent number	Other number
Medical and dental	299	294	5
Administration and estates	452	452	-
Healthcare assistants and other support staff	423	423	-
Nursing, midwifery and health visiting staff	625	625	-
Scientific, therapeutic and technical staff	241	241	-
Healthcare science staff	97	97	-
Social care and staff	4	1	3
Agency and contract staff	27	-	27
Bank staff	132	132	-
Other	99	99	-
Total	2,399	2,364	35
Of which: Engaged on capital projects	8	8	-

The average number of employees is calculated on the basis of the number of worked hours reported. This means that the reporting of staff numbers and staff costs incurred are on a more consistent basis.



## Employee Expenses

	Total £000	Permanent employed £000	Other total £000
Salaries and Wages	85,406	84,520	886
Social security costs	7,928	7,928	-
Pension cost – NHS pensions	10,150	10,150	-
Pension cost – other	10	10	-
Termination benefits	100	100	-
Temporary staff – Agency/contract staff	3,395	-	3,395
<b>Total Gross Staff Costs</b>	<b>106,989</b>	<b>102,708</b>	<b>4,281</b>
Included within; costs capitalised as part of assets	370	370	-

## Exit Packages

2016/17	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
Exit package cost band			
< £10,000	-	13	13
£10,001 - £25,000	1	-	1
£25,001 - £50,000	-	1	1
Total number of exit packages by type	1	14	15
Total resource cost (£000)	23	77	100

2015/16	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
Exit package cost band			
< £10,000	1	9	10
£10,001 - £25,000	-	1	1
£25,001 - £50,000	-	1	1
Total number of exit packages by type	1	11	12
Total resource cost (£000)	8	69	77

The payments included in 'Other departures' agreed for 2016/17 are in respect of contractual payments made in lieu of notice (2015/16 eleven payments for lieu of notice). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in this table.

## The Disclosures set out in the NHS Foundation Trust Code of Governance

Dorset County Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issues in 2012.

The requirements of section C1.1 of the code of Governance are covered within the Directors' Report and the Annual Governance Statement contained within this document.

The Board reviews its effectiveness of systems of internal control via assurance from the Chair of the Audit Committee in relation to their annual work programme.

### Board of Directors

The Board of Directors' primary role is to lead the Trust and set the Trust's strategic direction and objective and ensure that delivery of these is achieved within planned resources. The Board composition is as follow:

- Chair
- Six Non-Executive Directors
- Six Executive Directors
  - Chief Executive
  - Director of Finance and Resources
  - Medical director
  - Director of Nursing and Quality
  - Chief Operating Officer
  - Director of Organisational Development and Workforce

The Trust also has one non-voting Executive Director who is in attendance at Board meetings.

- Director of Strategy and Business Development

The Chair and Non-Executive Directors come from a range of professional backgrounds and succession planning is kept under review to ensure that Non-Executive Directors skills and experience reflect the evolving needs of the Trust. The Trust is confident that Executive Directors and Chair are independent in character and there are no relationships or circumstances which are likely to affect, or could appear to affect, their judgment.

The Trust has made the following appointments to the Board during 2016/17:

- A Director of Nursing and Quality who commenced on 1 September 2016.
- Three Non-Executive Directors who commenced on 1 September 2016.

The Board has in place a Scheme of Delegation and a Schedule of Powers and Decisions Reserved to the Board to ensure that decisions are taken at the appropriate level. Governors are provided at induction with full details of the roles and responsibilities of the Council of Governors.

The Board has the following key functions:

- To formulate strategy;
- To ensure accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
- Shaping a positive culture for the Board and the organisation;
- To, individually and collectively, act with a view to promoting the success of the Trust so as to maximise the benefits for the members as a whole and for the public;
- To maintain and improve quality of care;
- To ensure compliance with all applicable law, regulation and statutory guidance;
- To work in partnership with patients, carers, local health organisation, local government authorities and others to provide safe, effective, accessible and well governed services for patients.

Non-Executive Director appointments, including that of the Chair, are made by the Council of Governors. The Council of Governors is also responsible for approving the appointment of the Chief Executive. All Board level appointments are made using fair and transparent selection processes, with specialist Human Resources input and external assessors as required.

In accordance with the NHS Foundation Trust Code of Governance, the Chair and Non-Executive Directors have a fixed tenure of three years renewable with a further period of three years, subject to satisfactory annual performance appraisal and the agreement of the Council of Governors. Any term beyond six years for a Non-Executive Director would be subject to particularly rigorous review, and would take into account the need for progressive refreshing of the board. Non-Executive Directors may, in exceptional circumstances, serve longer than six years but this would be subject to annual re-appointment to a maximum of nine years in total. The circumstances in which a Non-Executive Director contract may be terminated early are set out in the Trust's Constitution and included in Non-Executive Director Terms and Conditions.

The Trust has in place a formal annual appraisal process for both Executive and Non-Executive Directors carried out against agreed objectives. The Chief Executive appraises

other Executive Directors, the Chair appraises the Chief Executive and Non-Executive Directors. The appraisal of the Chair is led by the Senior Independent Director. The outcomes of Executive Directors' appraisals are shared with the Remuneration and Terms of Service Committee, and those of the Chair and Non-Executive Directors with the Nominations and Remuneration Committee.

## **Board of Directors' Profiles**

### **Chair**

#### **Mark Addison – first term 24/3/2016 – 23/3/2018**

Mark has had an executive career in central government, working in senior operational and policy roles in a number of departments. He was the Chief Executive of the Crown Prosecution Service, Director General for Operations in the Department of Environment, Food and Rural Affairs, and was for a short spell the permanent Secretary of that Department and Chief Executive of the Rural Payments Agency. He has previously held non-executive roles, sitting on the boards of The National Archives and the Which? Council. He was the Chair of the Nursing and Midwifery Council. Mark remains a Public Appointments Assessor and a member of the Advisory Committee on Business appointments. These commitments have no impact upon his ability to chair Dorset County Hospital NHS Foundation Trust.

### **Chief Executive**

#### **Patricia Miller – appointed substantive Chief Executive 15 September 2014**

Patricia holds a Masters degree in Health Care Management from Manchester Business School, and is a graduate of the East of England aspiring Directors Programme. She is also a graduate of the Kings Fund Athena Programme – a leadership programme for executive women from across the public sector. She has worked for the NHS for over 20 years and was a member of the senior management at Bedford Hospital NHS Trust where she worked for nine years: her last role there was as Interim Chief Operating Officer. She has led a range of innovative and successful initiatives to improve patient safety and quality and has a proven track record in turning around hospital departments in financial difficulty, without impacting on service provision. Patricia joined the Trust in 2011 as Director of Operations and was appointed Chief Executive in 2014.

### **Non-Executive Directors**

#### **Peter Greensmith – first term 1/6/14 – 31/05/17. Vice Chair from 1/10/16**

Peter has extensive experience as a Board Director having served on six Boards. He has worked in the UK food and drink sectors, most recently on the board of Hall and Woodhouse Ltd as Chief Executive from 1991 to 2005. He also ran the Cow & Gate baby foods UK operation. He has previously been a Non-Executive Director for Avon and Wiltshire Mental Health Partnership NHS Trust.

**Matthew Rose – first term 17/6/14 – 16/6/17**

Matthew is a qualified accountant and a member of the Chartered Institute of Management Accountants. He has had a number of senior finance roles including previously working for Portsmouth Hospitals NHS Trust. He is a highly experienced senior commercial finance professional and has worked for New Look retailers based in Weymouth for the last 17 years. In his roles as Head of Finance he has the responsibility to implement the financial strategy to optimise the trading performance across all channels. He has extensive experience on strategic financial planning and budgeting and has a strong track record of challenging existing resources, systems and ways of working.

**Graeme Stanley – first term 1/10/13 – 30/9/16, second term 1/10/16 – 30/9/19. Senior Independent Director**

Graeme is a former Chief Executive of a South West based housing group. He is currently working in consultancy acting as Aster Group's Strategy and Implementation Director and is Chairman of Bracknell Forest Homes, Non-Executive Director Forest Future Homes Ltd and Non-Executive Director MB Crocker Ltd. He is a fellow of the Chartered Institute of Housing and holds an MSc in Strategic Management and Housing. Graeme's previous non-executive roles include non-Executive Director of the Independent Housing Ombudsman.

**Victoria Hodges – first term 1/9/16 – 31/8/19**

Victoria has had an executive career of over 25 years in the retail sector, with her remit covering all aspects of Human Resources and in particular organisation design, culture, change and leadership development. She has extensive experience of working with boards to drive business strategy and performance. Her most recent role was as People & Culture Director at White Stuff, which was ranked in the 'Times Top 100 Best Companies To Work For' for nine successive years under her leadership. She is a Trustee of the White Stuff Foundation.

**Judy Gillow – first term 1/9/16 – 31/8/19**

Judy has had an extensive and successful career in the NHS in clinical, operational management, educational and Executive Director roles. She was awarded an MBE in 2010 for her work on improving hospital infection rates and in 2016 she was awarded an honorary doctorate by Southampton University for her work on developing clinical academic careers for nurses and health professionals. Her most recent post was Director of Nursing at University Hospital Southampton where she led the quality improvement agenda. She is currently Senior Nurse Advisor for Health Education England, Wessex Branch, as well as a lay member of West Hampshire Clinical Commissioning Group. In addition she is a Specialist Advisor for the Care Quality Commission.

**Sue Atkinson - first term 1/09/16 – 31/8/19**

Sue has considerable experience in Public Health, clinical medicine, commissioning, as a chief executive, executive director and non-executive director in the NHS and DoH. She was Regional Director of Public Health (RDPH) for London and developed the role as Health

Advisor to the Mayor and Greater London Authority. She was previously RDPH and Medical Director of South Thames, South West Region and Wessex. Her work includes health strategy, inequalities and partnership working, including with national and local government and the third sector. Sue holds a number of non-executive and academic posts, including founding Director and Chair of PHAST (Public Health Action Support Team – a not for profit social enterprise). She is a Board Member of the Faculty of Public Health, Visiting Professor at UCL, Co-Chairs the Climate and Health Council and was a board member of the Food Standards Agency.

### **Non- Executive Directors who left during 2016/17**

#### **Martin Earwicker – first term 1/10/13 – 30/9/16, Vice Chair**

Retiring from his post as Vice Chancellor and Chief Executive of London South Bank University in 2013, Martin has considerable experience as a Chief Executive of major scientific, cultural and higher education institutions, with previous roles including Director and Chief Executive of the National Museum of Science and Industry and Chief Executive of the Defence Science and Technology Laboratory. Martin has significant non-executive experience as a Board member of the NHS South London Local Education and Training Board and Chair of Tower Hamlets College in London. He is a fellow of the Royal Academy of Engineering and was the recipient of an Honorary Doctorate from the University of Surrey in 2009.

#### **Jane Reid – first term 1/11/10 – 31/10/13, second term 1/11/13 – 31/10/16 (left 31/08/16)**

A Nurse by profession, Jane has extensive experience as an executive lead in the NHS and Higher Education. A post President of the Association for Perioperative Practice and formerly Nurse Advisor to the National Patient Safety Agency and the World Health Organisation, Jane has successfully led a number of national and international initiatives, focussed on patient safety improvement. Jane is Chair of the Health Education England Learning to be Safer Programme, Clinical Lead for Wessex Academic Health Science network Patient Safety collaborative, Regional Lead for Sign Up to Safety and Visiting Professor to Bournemouth University. A widely published Nurse Academic, Jane now combines a portfolio of research, education and review, providing independent advice in support of innovation and service improvement in the NHS.

### **Executive Directors**

#### **Chief Operating Officer (and interim Director of Nursing and Quality until 31 August 2016): Julie Pearce – appointed 26 May 2015**

Julie joined the Trust in May 2015 from East Kent Hospitals University Foundation Trust where she held a combined role of Chief Nurse and Chief Operating Officer. Julie is a first level Registered Nurse with specialist qualification in critical care nursing and holds BSc and MSc in Nursing Studies. She has worked in a number of acute teaching hospitals in Leeds, London, Birmingham, Cardiff and Southampton before becoming the nursing advisor for acute and specialist services at the Department of Health. In 2004 Julie took up her first Director post as Chief Nurse for Hampshire and Isle of Wight Strategic Health Authority and then moved to East Kent Hospitals in 2007. Julie's passions are the provision of person-

centred, high quality services through continuous service improvement and innovation. She has a good track record in leading and developing clinical services across a network of acute and community hospitals.

**Director of Finance and Resources: Libby Walters – appointed 12 September 2012**

Libby came to the Trust in September 2012 from Yeovil District Hospital NHS Foundation Trust where she was Director of Finance and Deputy Chief Executive. Libby has worked in the NHS for 22 years and has a track record of ensuring strong financial performance. She has a particular interest in ensuring the focus on use of resources is intrinsically linked with improving the quality of care provided. Graduate of the NHS South West Top Leaders programme (2010) for aspiring Chief Executives.

**Medical Director: Paul Lear – appointed 1 October 2011**

Paul qualified from London University in 1975. Following further periods of training in the Midlands and in Boston, USA, he was appointed to his first consultant position in 1988, at London's St Bartholomew's Hospital. In 1991, Paul moved to Bristol to practise as a specialist vascular and renal transplant surgeon, from where he has also worked closely with the renal service at Dorchester. Paul was the inaugural clinical Director of surgery and the then newly merged Frenchay and Southmead Hospitals (now North Bristol Trust) and maintained this role for 10 years.

**Director of Nursing and Quality: Alison Tong – until 1 August 2016 (on secondment from 1 April 2016 to 1 August 2016)**

Alison has wide experience and track record of improving standards of care and patient experience through developing leadership at the bedside. Alison has worked in a variety of acute hospitals across the UK including two large teaching hospitals. She has a proven track record of improving infection control practice and patient safety initiatives. First level registered nurse with a specialist qualification in orthopaedics, BSc (Hons) in Health Studies, qualified Neuro-Linguistic Practitioner and graduate of the NHS South West Top Leaders programme (2010) for aspiring Chief Executives.

**Director of Nursing and Quality: Nicky Lucey – appointed 1 September 2016**

Nicky joined the Trust from Kent Community Health NHS Foundation Trust where she was Director of Nursing and Quality. During her career Nicky has held a number of senior roles, including director of clinical standards at Portsmouth Hospitals NHS Trust. Her wealth of experience includes having successfully led many initiatives, such as workforce redesign involving education and career development, as well as patient care improvements. Nicky, who trained at Uxbridge, Middlesex, also has an MBA from Solent University. She has a professional background in cardiothoracic and critical care.

**Director of Organisational Development and Workforce: Mark Warner – appointed 2 March 2015**

Mark formerly worked for Buckinghamshire Healthcare NHS Trust from July 2013 and was responsible for leading the people agenda for the Trust. Previously, he was Head of Human

Resources at West Sussex County Council. Mark has more than 25 years' experience in the field of HR, including 18 years in the airline industry with British Airways.

**Director of Strategy and Business Development: Nick Johnson – appointed 1 February 2016 (non-voting)**

Nick joined the Trust from University Hospital Southampton NHS Foundation Trust where he was responsible for strategy and commercial development projects, including establishing and innovative commercial development joint venture, for which he was a Board Member. Prior to that, he was responsible for business development and bid management at a large, multi-national infrastructure and support services provider focusing on strategic public private partnerships. Nick has also worked in a number of local authorities delivering innovative strategic partnerships, contract management and service transformation. Nick has an MSc from Warwick Business School and started his career on the National Graduate Management Scheme for Local Government.



### Attendance at Trust Board Meetings 2016/17

P= Public C=Confidential	April		May	June		July		August	September		December		January		March	
	P	C	C	P	C	P	C	C	P	C	P	C	P	C	P	C
Non- Executive Directors																
Mr Mark Addison	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
Mr Peter Greensmith	P	P	P	P	P	P	P	A	P	P	P	P	A	A	P	P
Mr Graeme Stanley	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
Mr Matthew Rose	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
Ms Victoria Hodges	N	N	N	N	N	N	N	N	P	P	P	P	P	P	P	P
Ms Judy Gillow	N	N	N	N	N	N	N	N	P	P	P	P	P	P	P	P
Prof Sue Atkinson	N	N	N	N	N	N	N	N	A	A	P	P	A	A	P	P
Dr Martin Earwicker	P	P	A	P	P	P	P	P	P	P	N	N	N	N	N	N
Professor Jane Reid	A	A	P	P	P	A	A	P	N	N	N	N	N	N	N	N
Executive Directors																
Ms Patricia Miller	P	P	P	P	P	A	A	P	P	P	P	P	P	P	P	P
Ms Libby Walters	P	P	P	P	P	A	A	P	P	P	P	P	P	P	P	P
Mr Paul Lear	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
Ms Julie Pearce	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
Mr Mark Warner	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
Ms Nicky Lucey	N	N	N	N	N	N	N	N	P	P	P	P	P	P	P	P
Mr Nick Johnson	P	P	P	A	A	P	P	A	P	P	P	P	P	P	P	P

Key    P – Present  
           A – Apologies  
           N – Not applicable

## Council of Governors

The Council of Governors is made up of elected and appointed representatives from members of the public, staff and stakeholder organisations. It consists of 28 Governors (16 elected Public Governors, 4 elected Staff Governors and 8 Appointed Governors). The Trust membership elects the Public and Staff Governors and it is part of the elected Governor role to represent the members of their constituencies and communicate their views to the board. The Trust has a duty to ensure that its members are engaged in and kept up to date with developments within the hospital and its services.

The Council of Governors plays a vital part in the work of the Trust including statutory duties. The Council of Governors' specific statutory duties are:

- Appoint and, if appropriate, remove the Chair
- Appoint and, if appropriate, removed the other Non-Executive Directors
- Decide the remuneration and allowance and other terms and conditions of office of the Chair and other Non-Executives
- Approve the appointment of the Chief Executive
- Appoint and, if appropriate, remove the Trust's External Auditor
- Receive the Trust's annual accounts, any report of the Auditor on them and the Annual Report
- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors
- Represent the interests of the members of the Trust as a whole and the interests of the public
- Approve "significant transactions"
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Approve any increase by 5% or more the proportion of the Trust's total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England
- Approve amendments to the Trust's constitution

The Council of Governors meets on a quarterly basis.

## Attendance at Council of Governor Meetings 2016/17

(4 regular quarterly meetings, 1 additional meeting to approve changes to the Constitution and 1 part two meeting to approve the reappointment of a Non-Executive Director)

Members and Constituency	Current Tenure	Attendance at Council of Governors
--------------------------	----------------	------------------------------------

### ELECTED GOVERNORS

Jane Holdaway	West Dorset	10/07/15 – 09/07/18	2 /6
David Cove	West Dorset	01/06/13 – 31/05/17	5/6
Christine Case	West Dorset	10/07/15 – 09/07/18	4/6
Les Fry	West Dorset	10/07/15 – 09/07/18	3/6
David Tett	West Dorset	10/07/15 – 09/07/18	5/6
Michel Hooper-Immins	Weymouth and Portland	10/07/15 – 09/07/18	5/6
Andy Hutchings	Weymouth and Portland	10/07/15 – 09/07/18	5/6
Edward Gibbs	Weymouth and Portland	01/06/13 – 31/05/17	4/6
Sharon Waight	Weymouth and Portland	10/07/15 – 09/07/18	2/6
Christine McGee	North Dorset	10/07/15 – 09/07/18	6/6
Peter Coghlan	East Dorset, Christchurch, Poole and Bournemouth	01/06/13 – 31/05/17	3/6
1 VACANCY	East Dorset, Christchurch, Poole and Bournemouth		
1 VACANCY	North Dorset		
1 VACANCY	West Dorset		
1 VACANCY	Weymouth and Portland		
1 VACANCY	South Somerset		

## **STAFF GOVERNORS**

Duncan Farquhar-Thomson	Staff (Lead Governor)	01/06/13 – 31/05/17	6/6
Piet Bakker	Staff	01/06/13 – 31/05/17	4/6
Ron Martin	Staff	10/07/15 – 09/07/18	6/6
1 VACANCY	Staff		

## **APPOINTED GOVERNORS (the Trust has two unfilled appointed Governors)**

Peter Wood	Age UK	*	4/6
Jenny Bubb	Dorset Clinical Commissioning Group	*	3/6
Ian Gardiner	Dorset County Council	*	3/6
Annette Kent	Friends of DCH	*	2/2
Paul Bithell	Dorset Kidney Fund	*	2/2
Davina Smith	Weldmar Hospicecare Trust	*	2/2

## **GOVERNORS WHO LEFT DURING THE YEAR**

Ian Sedwell	Weymouth and Portland	10/07/15 – 01/11/16	3/4
Gladys Gundry	West Dorset	10/07/15 – 21/10/16	3/4
James Metcalfe	Staff	10/07/15 – 14/6/16	1/2
John Weir	Friends of DCH	*	2/4
Steph Vincent	Dorset Kidney Fund	*	0/4

\*appointed Governors hold office until the sponsoring organisation ceases to sponsor them.

Additionally, the Governors' Working Group meets on a more informal basis four times a year. These meetings are attended by Non-Executive Directors on a rotational basis.

There were no Governor elections during 2016/17.

During 2016/17 the Council of Governors maintained three committees to progress various aspects of the Council's work:

- Nominations and Remuneration Committee – to develop and deliver the selection and recruitment process for new Non-Executive Directors

- Membership Development Committee – to implement the Membership Strategy and develop communication and engagement mechanisms with the membership
- Constitution Review Committee - to review the Trust's Constitution to ensure it meets current Statutory and Local and National governance requirements.

Governors' contact details are available on the Trust's website [www.dchft.nhs.uk](http://www.dchft.nhs.uk) or correspondence can be sent to the Trust Secretary, Dorset County Hospital NHS Foundation Trust, Trust HQ, Williams Avenue, Dorchester, Dorset, DT1 2JY.

### **Nominations and Remuneration Committee**

The Nominations and Remunerations Committee's duties are to make recommendations to the Council of Governors in respect of:

- Regularly reviewing the terms and conditions, including the Job Description and Person Specification, of the Chair and Non-Executive Directors
- Developing and undertaking the selection processes for any new Chair and/or Non-Executive Director appointments
- Considering any extension of tenure of the Chair and Non-Executive Directors at the end of each term of office
- Reviewing annually the remuneration of the Chair and Non-Executive Directors
- Receiving detail of the annual appraisal of the Chair and Non-Executive Directors
- Regularly reviewing the skill mix of the Chair and Non-Executives to ensure it adequately reflects need
- Being involved in the appointment of the Chief Executive and making recommendation to the Council of Governors for approval.

The Nomination and Remuneration Committee comprises the Chair, Vice Chair (who chairs the Committee when issues relating to the Chair are under discussion), the Lead Governor, four elected Public Governors, two elected Staff Governors and one appointed Governor. The Chief Executive, Director of Organisational Development and Workforce and the Trust Secretary are also in attendance as required.

The Nominations and Remuneration Committee convened twice during the period. The meetings took place on 9 September 2016 and 17 October 2016.

Nominations and Remuneration Committee	Number of meetings attended
Mark Addison – Chair	2/2
Peter Greensmith – NED/Vice Chair	0/2
Michel Hooper-Immins – Public Governor	2/2
Andy Hutchings – Public Governor	1/2
Christine McGee – Public Governor	2/2
David Tett – Public Governor	0/2
Peter Wood – Appointed Governor	2/2
Duncan Farquhar-Thomson – Staff Governor/Lead Governor	0/2

### How the Board and Governors Work Together

Governors are allocated time at the end of each Board meeting to ask questions of the Board on behalf of members or to relay members views. In addition, Governors are able to contact Trust Officers at any time outside of formal meetings in relation to members' feedback and/or questions.

Nominated Governors are invited to attend Board Committee meetings (with the exception of Remuneration and Terms of Service Committee) and the Clinical Governance Committee as observers. Governors also sit as lay members on the Learning from Patients Committee.

The Trust encourages its Governors to engage with the public and members through circulation of regular membership newsletters and by holding Governor and member events on topics of interest to patients and the public and an annual Open Day.

Governors provide the Trust with an independent quality assurance mechanism through the conduct of visits to ward areas to assess patients' privacy and dignity, ward cleanliness and other aspects of the ward environment.

Non-Executive Directors are invited to attend formal Council of governor meetings, Governors Working Group, Membership Development Committee and membership events as additional opportunities to develop relationships. During this year the Trust has also instigated a "buddying" system between Non-Executive Directors and Governors based on location.

In the event of a disagreement between the Council of Governors and the Board of Directors, the Dispute Resolution process referred to in the Trust's Constitution (Annex 8) will be invoked.

**Director Attendance at Public Council of Governors' Meetings during 2016/17**

Name	Title	Attendance/ Meetings eligible to attend
Mr Mark Addison	Chair	5/5
Mr Peter Greensmith	Vice Chair	2/5
Mr Graeme Stanley	Non-Executive Director	1/5
Mr Matthew Rose	Non-Executive Director	2/5
Ms Victoria Hodges	Non-Executive Director	0/2
Ms Judy Gillow	Non-Executive Director	0/2
Prof Sue Atkinson	Non-Executive Director	0/2
Dr Martin Earwicker	Non-Executive Director	2/3
Professor Jane Reid	Non-Executive Director	0/3
Ms Patricia Miller	Chief Executive	5/5
Ms Libby Walters	Director of Finance and Resources	3/5
Mr Paul Lear	Medical Director	0/5
Ms Julie Pearce	Chief Operating Officer	2/5
Mr Mark Warner	Director of OD and Workforce	2/5
Ms Nicky Lucey	Director of Nursing and Quality	1/2
Mr Nick Johnson	Director of Strategy and Business Development	1/5

\*In July 2016 it was agreed that Non-Executive Directors would attend Council of Governors on a rotational basis, prior to this attendance had been on a discretionary basis. Executive Directors attend as appropriate to present specific items. Non-Executive Directors attend Governors' Working Group (informal) meetings on a rotational basis.



## Membership of the Trust

Foundation Trusts have a responsibility to engage with the communities that they service and listen to community views when planning services.

The Trust has two types of membership: public and staff. The Trust encourages people who live within its constituency boundaries to register as public members. Being a member demonstrates support for the hospital and the services it provides and gives the opportunity to share views with the Trust to help it best meet patient needs.

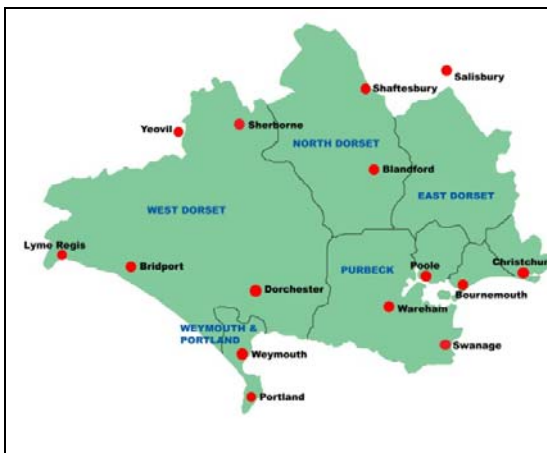
Membership is open to people ages 16+ years who live in one of the Trust's public constituencies. Registration as a member can be via a membership application form from hospital reception areas, online at [www.dchft.nhs.uk](http://www.dchft.nhs.uk), via email to [foundation@dchft.nhs.uk](mailto:foundation@dchft.nhs.uk), or by phoning 01305 255419.

The Council of Governors has established a Membership Development Committee which meets on a quarterly basis to keep the Membership Strategy under review and oversee membership communications, events and recruitment.

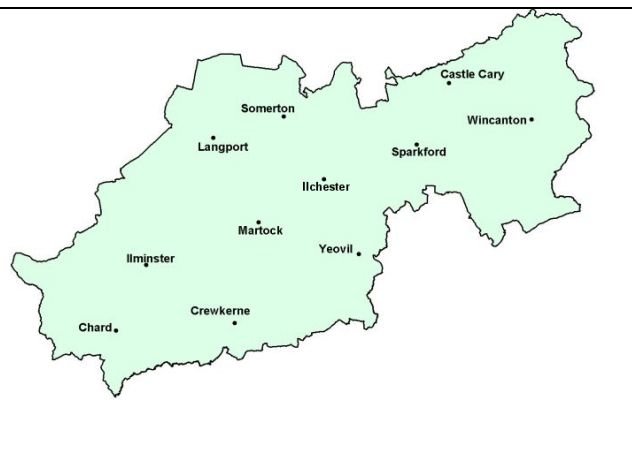
The Trust has maintained a fairly steady level of membership throughout 2016/17 despite efforts by Governors and staff. It is felt that the elderly demographic may contribute to the challenges in recruitment.

Membership engagement rather than size is the Trust's key focus, with a series of membership events held throughout the year, hard copy and electronic membership newsletters and a successful Trust Open Day in October 2016.

Dorset



South Somerset



Constituency	2016/17	2015/16
West Dorset	1,476	1,481
Weymouth and Portland	874	885
North Dorset	323	327
South Somerset and out of area	87	83
Purbeck, East Dorset, Christchurch, Poole and Bournemouth	268	272
<b>Total Public Constituencies</b>	<b>3,028</b>	<b>3,048</b>
<b>Staff</b>	<b>3,396</b>	<b>3,345</b>
<b>Total</b>	<b>6,424</b>	<b>6,393</b>

## Auditors

The Trust's audit services from 1 April 2016 to 31 March 2017 were provided as follows:

- Internal Auditors – KPMG – appointed October 2013 – the internal audit plan is risk based and is developed annually in conjunction with Executive Directors. The draft plan is then agreed by the Audit Committee. The plan comprises both financial and clinical quality audit work, in addition to reviews of areas which are considered by Executive Directors and/or Internal Audit to be high risk or of concern.
- External Auditors – BDO- appointed July 2014 – external auditors prepare and present an annual plan of work to review the financial management and reporting systems of the Trust and provide assurance that the annual accounts and supporting financial systems are operating effectively. Should external auditors be asked to provide non audit services, this has to be in line with the Trust's policy on Engagement of External auditors for Non-Audit Services.

The Trust undertakes a formal tender process for the appointment of both Internal and External Audit.

## Audit Committee

The Audit Committee provides assurance to the board on the effectiveness of the Trust's systems of governance and control across the full range of the Trust's responsibilities. It does this by receiving and testing assurance provided in relation to the establishment and maintenance of effective systems of governance, risk management, finance, counter fraud and internal controls and assures itself regarding the Trust's compliance with regulatory, legal and other requirements. The Audit Committee's remit encompasses healthcare assurance as well as the more traditional audit areas of finance and corporate governance.

Internal Audit assists the Audit Committee by providing clear statements of assurance regarding the adequacy and effectiveness of internal control. The Director of Finance and Resources is professionally responsible for implementing systems of internal financial control and is able to advise the Audit Committee on such matters.

At its meeting on 22 May 2017 the Audit Committee considered the financial statements and agreed that they contained no significant issues that required addressing under the terms of the UK Corporate Governance Code 2014, para C3.8.

The Committee has reviewed its performance and in line with other Board Committees nominate Governors are invited to attend and observe Audit Committee meetings.

Arrangements for allowing staff to raise concerns are detailed in the Trust's Whistleblowing Policy which was reviewed during 2016/17 by the Partnership Forum. The Chair of Audit is the Trust's current Freedom to Speak Up Guardian.

### Audit Committee Attendance

Name	Title	Attendance/ Meetings eligible to attend
Mr Graeme Stanley	Audit Committee Chair	6/6
Mr Peter Greensmith	Non-Executive Director	3/3
Mr Matthew Rose	Non-Executive Director	5/6
Prof Sue Atkinson	Non-Executive Director	3/3

## NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

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

Based on information from these, 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. Comparative information relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

### Segmentation

NHS Improvement has placed the Trust in Segment 2 as at the 31<sup>st</sup> March 2017. Segment 2 is Providers offered targeted support.

### 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.

## DCHFT Annual Report and Accounts 2016/17

Area	Metric	2016/17 Q3 Score	2016/17 Q4 Score
Financial Sustainability	Capital service capacity	2	2
	Liquidity	2	2
Financial Efficiency	I&E margin	4	3
Financial Controls	Distance from financial plan	2	1
	Agency spend	2	2
Overall Scoring		3	2

## Sustainability Report

### Introduction

The Trust recognises its impact on the environment. This ranges from local to global impacts, from air pollution to climate change and from river pollution to use of natural resources. In line with its Sustainability Policy the Trust is committed to reducing its environmental impact.

The main contributing gases, known as Greenhouse Gases, are water vapour, methane and carbon dioxide. The volumes of greenhouse gases emitted by human activity have increased significantly as our dependence on fossil fuels has increased. If climate change trends continue, the Earth is set to experience increasing temperatures, increased rainfall and flooding, increased desertification, droughts and rising sea levels. The social, environmental and economic costs of climate change will be immense.

In Dorset the effects of climate change are likely to include increased risk of extreme weather, more regular flooding, and changes to biodiversity.

The NHS makes a significant contribution to the UK's carbon dioxide emissions. The size of the organisation ensures that there is significant potential to reduce these emissions. Because of the large number of people that the NHS encounters, there is an opportunity to influence attitudes towards sustainability.

The running of an NHS Trust involves many activities that can have a significant impact on the environment. These include the use of energy and water, the creation of waste and the use of natural resources via the procurement of goods and services. The Trust has looked at these activities to investigate ways in which their environmental impact can be reduced.

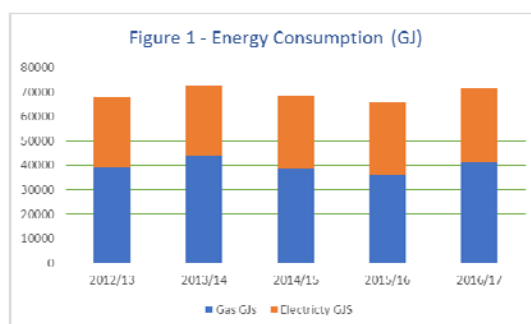
A key project that will help the Trust reduce its carbon contribution is the replacement of plant equipment through the Carbon Energy Fund. The Estates Department has considered a number of applications from companies over the last year with the intent to reduce electricity and gas consumption. The reductions will be possible through replacing boilers, recycling excess heat and installing more LED light fittings.

The Trust measures a number of key indicators to assist with the monitoring of environmental performance. These comprise quantifiable indicators such as utility usage and waste generation. Quantifiable indicators are reported to the Department of Health through the Estates Returns Information Collection (ERIC) process. The Trust will continue to develop more accurate key performance indicators as the management of our environmental impact progresses.

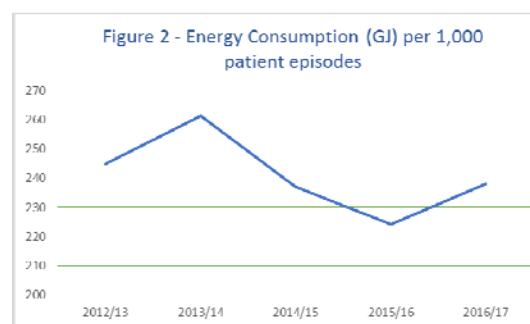
### Energy Use

Figures 1 - 4 show a summary of energy consumption and associated CO<sub>2</sub> emissions for the period 2012/13 to 2016/17. For the purposes of NHS and HM Treasury reporting, energy consumption is shown in gigajoules (GJ) and kilowatt-hours (kWh). Please note February and March 2017 figures are estimates based on usage in February and March 2016 due to data being unavailable at the time of writing.

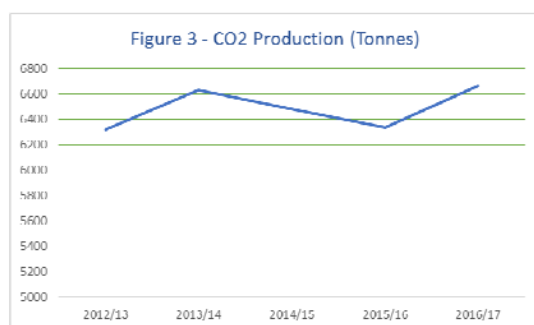
## DCHFT Annual Report and Accounts 2016/17



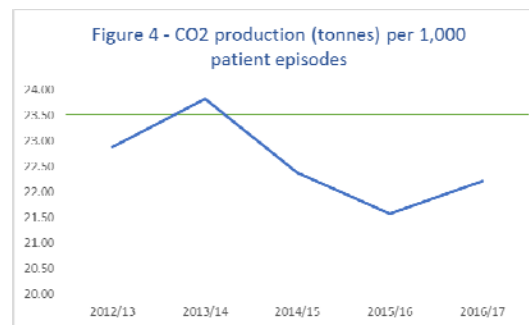
**Figure 1** - Gas consumption increased from 36,097 GJ in 2015/16 to 41,204 GJ in 2016/17, a 14.1% increase. Electricity consumption increased from 29,694 in 2015/16 to 30,142 GJ 2016/17, a 1.5% increase.



**Figure 2** - energy consumption per 1,000 patient episodes increased from 224.09 GJ in 2015/16 to 237.82 GJ in 2016/17, a 6.1% increase.



**Figure 3** - CO<sub>2</sub> production increased by 329 tonnes during the year compared to 2015/16 to 6665 tonnes. This is an increase of 5.2%.



**Figure 4** - CO<sub>2</sub> production per 1,000 patient episodes increased from 21.58 in 2015/16, to 22.22 in 2016/17. This is an increase of 3%.

Despite the upward trends in energy use, the Trust has implemented a number of initiatives to channel improvement in this area including:

Accurate monitoring of energy and use of real data over assumptions

LED light fittings are installed whenever a fitting needs adding or replacing

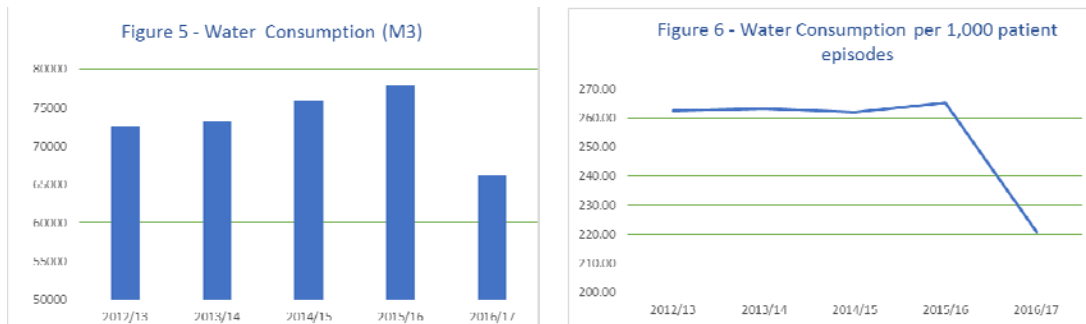
Presence sensor devices are installed during alterations to the building

- Effective maintenance regime for boilers as part of the Trusts Planned Preventative Maintenance schedule
- Continued promotion of energy conservation through a sustainability day, inclusion in the induction programme for new starters, and regular promotional events

## Water Use

**Figures 5 and 6** provide a summary of water consumption during the period 2012/13 to 2016/17. Consumption is shown in cubic metres (M<sup>3</sup>). Please note February and March 2017

figures are estimates based on usage in February and March 2016 due to data being unavailable at the time of writing.



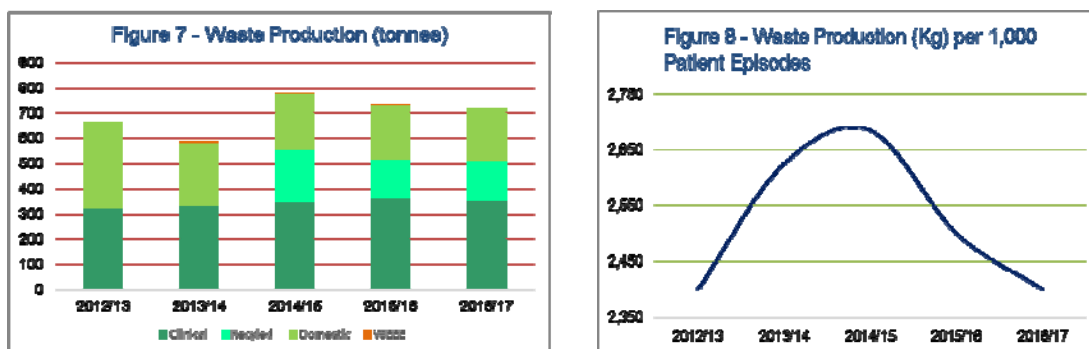
**Figure 5** - water consumption fell from 77,807 M<sup>3</sup> in 2015/16 to 66,206 in 2016/17. This is a 14.9% reduction.

**Figure 6** – water consumption per 1,000 patient episodes fell from 265.01 in 2015/16 to 220.69 in 2016/17. This is a 16.7% reduction.

The Trust remains committed to reducing water consumption. Water efficiency measures implemented during 2016/17 include:

- Robust monitoring of water usage
- Educating staff about water usage in their induction
- More intelligent outlet flushing as part of the water hygiene process
- Priority given to resolve water leaks throughout the estate

### Waste



**Figure 7** - Overall waste production for 2016/17 stood at 717.1 tonnes compared to 734.6 tonnes in 2015/16. This shows a 2.4% reduction.

**Figure 8** - waste production per patient episode fell from 2.5kg in 2015/16 to 2.4kg in 2016/17. This is a 4.4% reduction.



Of the total waste produced, 21.8% was recycled matching the 2015/16 figure of 22%.

The Trust remains committed to reducing waste. Waste reduction measures implemented during 2016/17 include:

- Patient meal ordering changed to per meal as opposed to daily. This allows for changing appetites and early discharges
- Use of crockery design to encourage patients to finish their meals
- Encourage mixed recycling to build on the initial implementation from 2015

### **Fugitive Emissions**

The Trust has a robust contracted maintenance regime in place to minimise Fluorinated Gas losses. Gas top ups are recorded to indicate where losses may have occurred.

### **Procurement**

The Trust continues to ensure that sustainable development is integrated throughout the procurement process. Measures implemented to-date to promote this include:

- Whole life cycle training for key procurement staff
- Intelligent inventory management
- Ensuring key contracts contain sustainability criteria
- Increased partnership working with key suppliers to further promote sustainability within the Trust
- Continue to use sustainable products (e.g. FSC wood)
- Inclusion of environmental appraisals prior to tendering for significant goods and services
- Introduction of quality assurance and sustainable and ethical standards in the procurement of food items

### **Transport**

As part of the HM Treasury requirement to report on sustainability, the Trust is required to report the following on an annual basis;

- Emissions relating to official business travel directly paid for by the Trust.
- Total expenditure on official business travel.

Total business mileage during 2016/17 was 1,210,274 miles, an increase of 24.7% over the 2015/16 figure of 970,441. The cost of business mileage fell by 10.4%, helped by lower fuel prices more efficient use of the pool car fleet.

The Trust continues to promote more sustainable forms of transport via the transport group. Actions undertaken by the Trust to encourage low carbon travel and transport include:

- The continual assessment and review of transport needs via travel surveys
- Promotion of sustainable transport measures to all staff
- Regular joint meetings with Dorset County Council and local transport companies to promote the use of sustainable transport such as membership of First Bus Corporate Travel Club
- Increased the number of cycle storage facilities
- Close work with Sustran and Dorset County Council to encourage increased walking and cycling and how the routes could be improved in order to encourage more uptake

### **Building and Refurbishment**

The Trust continues to ensure compliance with the Building Performance Directive and ensure that updated Display Energy Certificates (DEC) are in place.

Building projects specify the use of environmentally friendly materials and disposal methods.

### **Sustainable Development Management Plan (SDMP)**

The Trust has continued to develop and strengthen its Sustainable Development Management Plan in line with its Sustainable Development Strategy. Each section of the SDMP has a number of key tasks to contribute towards the targets listed below. The performance against the tasks is reviewed at regular Sustainability Working Group meetings.

The SDMP targets are listed below:

### **Energy and Carbon Management**

- Reduce energy consumption to 38 kwh per patient episode by 2020.
- Reduce energy consumption from buildings by 34% by 2020 (based on 2007 levels)

Both targets will be heavily affected by the implementation of plant machinery upgrades via the Carbon Energy Fund in 2017/18.

### **Low Carbon Travel, Transport and Access**

- Reduce carbon emissions from transport by 34% by 2020 (compared to 2012/13 levels).

The SDMP tasks have been completed or are in progress. Encouraging the use of electric vehicles has been considered but is limited by current technology given the wide distances patients and staff often travel in West Dorset. This will continue to be monitored as battery technology improves.

### Water

- Reduce water consumption to 130 litres/patient episode by 2020

Tasks largely complete or in progress. More work is to be completed on outlet flushing for Legionella prevention to further minimise water use.

### Waste

- Ensure legal compliance with waste legislation.
- Increase recycling rates by 40% by 2020 (based on 2001/02 levels)
- Reduce waste by 20% by 2020 (based on 2001/02 levels)

Tasks are completed or in progress. There is further work to do on implementing mixed recycling in all areas of the hospital. There are some space limitations to overcome to allow different bins to be situated in all areas.

### Designing the Built Environment

- Ensure that all new builds and refurbishments over £2 million (capital costs) comply with Bream New Construction requirements.

There have been no capital projects that meet the cost threshold of £2 million.

### Organisational Workforce Development

- Ensure that sustainability is communicated throughout the Trust and ensure that employees receive relevant training.

Tasks have largely been completed. Some other NHS priorities have meant that inclusion in the board agenda and active discussions at board level have been limited.

### Role of Partnerships and Networks

- To work in partnership with local groups and key stakeholders in order to support sustainable development in South West of England.

Partnership working has improved with stakeholders and other trusts. This is expected to continue to improve as joint working within the NHS increases.

### Governance

- Ensure that sustainable development is consistently managed in line with the Trust's Sustainable Development Policy and Strategy.

Tasks have been implemented and are reviewed in the Sustainability Working Group meetings.

## Finance, Procurement and Food

- Ensure sustainable development is integrated within finance, procurement and food departments.

Representatives from these areas attend the Sustainability Working Group meetings and cascade news and decisions through their departments.

## Data

The tables below show the data used in the formation of the sustainability section of the annual report

**Table 1**

Energy consumption	2012/13	2013/14	2014/15	2015/16	2016/17
Gas (1,000 GJ)	39.0	43.7	38.9	36.1	41.2
Electricity (1,000 GJ)	28.6	29.1	29.7	29.7	30.1
Total Energy (1,000 GJ)	67.6	72.8	68.6	65.8	71.3
Gas (1,000 kWh)	10,806.5	12,092.5	10,769.1	9,999.3	11,414.0
Electricity (1,000 kWh)	7,922.7	12,165.3	10,837.6	10,065.1	11,485.3
Total Energy (1,000 kWh)	18,729.1	24,257.8	21,606.7	20,064.4	22,899.3

**Table 2**

Energy consumption and emissions per patient episode	2012/13	2013/14	2014/15	2015/16	2016/17
Total Energy (1,000 kWh)	18,729.1	24,257.8	21,606.7	20,064.4	22,899.3
CO2 Emissions (100 tonnes)	63.2	66.3	64.8	63.4	66.7

## DCHFT Annual Report and Accounts 2016/17

Patient episodes (1,000's)	276.2	278.4	289.4	293.6	300.0
kWh per patient episode	67.8	87.1	74.7	68.3	76.3
CO2 Emissions per patient episode (kg)	22.9	23.8	22.4	21.6	22.2

**Table 3**

Energy financial indicators	2012/13	2013/14	2014/15	2015/16	2016/17
	£'000	£'000	£'000	£'000	£'000
Energy expenditure	1,427.1	1,201.1	1,279.1	1,280.5	1278.3
Carbon reduction commitment expenditure	77.3	76.4	102.2	96.5	-

**Table 4**

Water use & costs	2012/13	2013/14	2014/15	2015/16	2016/17
Water use (1,000m3)	72.5	73.2	75.8	77.8	66.2
Patient episodes (1,000's)	276.2	278.4	289.4	293.6	300.0
Water use per patient episode (litres)	262.4	262.9	261.9	265.0	220.7
Water and sewerage expenditure (1,000's)	228.4	235.2	262	215.2	176.1

**Table 5**

Waste production	2012/13	2013/14	2014/15	2015/16	2016/17
High temp clinical waste (tonnes)	48	47	49.6	42.8	41.0
Alternative treatment clinical waste (tonnes)	270	279	297.2	314.9	310.2

## DCHFT Annual Report and Accounts 2016/17

Total clinical waste (tonnes)	318	326	346.8	357.7	351.2
Domestic waste (tonnes)	342	252	222.3	216	208.2
WEEE (tonnes)	2.6	10.2	4.2	7.9	1.2
Recycling (tonnes)	-	143	204	153	156.5
Total waste (tonnes)	662.6*	731.2	777.3	734.6	717.1
% of waste recycled (including WEEE)	23%	20%	26%	21%	22%
Patient episodes (1,000's)	276.2	278.4	289.4	293.6	300*
Total waste (Kg) per patient episode	2.4	2.6	2.7	2.5	2.4

\*This figure is lower than the following years as robust recycling waste data was not available from the waste contractors

**Table 6**

Waste costs	2012/13 £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000
High temp clinical waste	28.86	28.56	28.76	27.51	13.56
Alternative treatment clinical waste	134.75	148.12	142.52	113.57	133.61
Total clinical waste	163.61	176.68	171.28	141.08	147.17
Domestic waste	52.72	42.52	31.26	39.78	33.43
WEEE	0.92	0.32	0.69	1.34	0.31
Total waste costs	217.25	219.52	203.23	182.20	180.91

**Table 7**

Business travel and costs	2012/13	2013/14	2014/15	2015/16	2016/17
Business mileage (miles)	1,131,500	1,113,840	956,562	970,440	1,210,274
Total expenditure on business travel (£)	396,554	498,563	484,394	462,199	414,108

Note: Figures shown for prior years may differ from those shown in last year's annual report. This is due to quarter four figures always being estimated and to date these have not been amended in subsequent years to show the actual figure. For the 2016/17 report, all of the historical information has been updated to reflect the ERIC returns.

## Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Dorset County 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 Dorset County 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 Dorset County Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

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

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable 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*.

Patricia Miller  
Chief Executive  
22 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*.

### 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 Dorset County 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 Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

### Capacity to Handle Risk

The Director of Nursing and Quality is the executive lead for risk management and is supported in this by the Head of Risk Management and Quality Assurance. The Trust has a Risk Management Committee, which reports to the Senior Management Team. The Board and Audit Committee receive the Corporate Risk Register and the Board Assurance Framework every two months. The Risk Management Strategy sets out the Board's requirement that a systematic approach to identify and manage risks is adopted across the Trust and that systems are in place to mitigate those risks where possible. The strategy also stipulates that it is essential that all Trust staff are made aware and have an understanding of the procedures in place to identify, report, assess, monitor and reduce or mitigate risk as far as possible.

The Trust's approach to risk management is pro-active and involves the following:

- identifying sources of potential risk and proactively assessing risk situations, and mitigating those risks as far as possible;
- identifying risk issues through the reporting of serious untoward incidents, adverse incidents, near misses, complaints and claims, and internal and external review reports;
- investigating and analysing the root causes of risk events;

- undertaking aggregated root cause analysis (considering risk events, complaints, claims and RIDDOR data);
- taking action to eliminate or at least minimise harmful risks;
- monitoring the delivery and effectiveness of actions taken to control risk;
- learning from near misses, risk events, legal claims and complaints and sharing the lessons learned across the organisation; and
- RCAs are reviewed at a 'Learning from Incidents' Panel which is chaired by the Medical Director and the Director of Nursing and Quality, which enables a positive challenge to the staff regarding the root cause, the learning and helps to identify any notable practice.

The Trust has adopted a coordinated and holistic approach to risk and does not differentiate the processes applied to clinical and non-clinical issues. Common systems for the reporting, identification, assessment, evaluation and monitoring of risk have been developed within the Trust and apply to all risk issues, regardless of type.

The effective implementation of the strategy facilitates the delivery of a quality service and, alongside staff training and support, provides an improved awareness of the measures needed to prevent, control and contain risk. To achieve this, the Trust:

- ensures all staff and stakeholders have access to a copy of the Risk Management Strategy;
- produces a register of risks across the Trust which is subject to regular review at Divisional level, by the Senior Management Team, Risk Management Committee, Audit Committee and the Board;
- communicates to staff any action to be taken in respect of risk issues;
- has developed policies, procedures and guidelines based on the results of assessments and identified risks;
- ensures that training programmes raise and sustain awareness throughout the Trust of the importance of identifying and managing risk;
- ensures that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with the strategy; and
- monitors and reviews the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk.

Risk training forms part of the Trust Induction training for clinical and non clinical staff. Risk training also form part of the preceptorship and junior doctors training. Specific training in Root Cause Analysis, statement writing and investigations is being developed to support this process.

### **The Risk and Control Framework**

The Trust acknowledges that all members of staff have an important role to play in identifying, assessing and managing risk. This can be achieved proactively, through risk assessment, or reactively, through review of risk events, complaints and legal claims. To support staff in this role, the Trust provides a fair, consistent environment that encourages a culture of openness and willingness to admit mistakes. All staff are encouraged to report when things have, or could have, gone wrong. At the heart of the Trust's Risk Management Strategy is the desire to learn from risk events and near misses, complaints and claims, in order to continuously improve management processes and clinical practice.

The Trust has in place clear policies and systems for identifying, evaluating and monitoring risk. Trust-wide risk profiling is an ongoing process and managers are required to ensure that risk assessment and audit is undertaken within their areas of responsibility and that findings are acted upon and adequately monitored. Managers are also responsible for ensuring that all risk assessments are reviewed as required.

The Trust's Risk Event Reporting Policy requires staff to report all adverse incidents, both actual and potential (near misses), and sets out the methodology and responsibilities for assessing and evaluating the risks. The impact of a risk will dictate at which level of the organisation the risk event is investigated and reported, with the lowest category (green) managed at a local level and the highest (red) managed at executive level with reports made to the Board and statutory external agencies.

The Trust manages risks to data security through a variety of means including, but not limited to, anti-virus and malware detection software. Issues to data security which are identified as high risk are escalated through the Trust's risk event reporting procedures and monitored through the risk registers, at both a local and corporate level. The Trust is compliant to a minimum Level 2 of the Information Security and Assurance standards within NHS Digital's Information Governance Toolkit and is currently incorporating the National Data Guardian recommendations into practice as well as working towards ISO27001 accreditation during the 2017-18 financial year.

During the first part of 2016/17, the Trust's main risks related to ophthalmology service capacity, financial sustainability and access to care in the community.

The Trust provides an Ophthalmology service which covers a large geographical area. This service covers a range of monitoring and interventions for a number of eye conditions, including glaucoma, cataracts and AMD. Demand placed on the service has previously exceeded capacity resulting in delays to outpatient and elective care. The Ophthalmology service has gone through a significant period of change in 2016/17 with more significant changes planned for 17/18. During 16/17 the following major changes have taken place – a workforce review completed to improving the skill mix of staff; a Glaucoma Referral Refinement scheme agreed for a 1 year trial with an aim to reducing glaucoma demand by

up to 20%; one stop laser clinics implemented. Looking forward to 17/18 the following schemes are set to start - Improving nursing efficiency in outpatients to increase throughput in clinics; Reviewing protocols around the routine follow up of post operative patients.

Along with these efficiencies the Trust is also introducing a new post in conjunction with Dorset Blind into the department called an Eye Clinic Liaison Officer. The role of an Eye Clinic Liaison Officer is to act as the link between the eye department and available services for people with sight problems and to provide them with both emotional and practical support when newly registered and on an ongoing basis.

Achieving the financial control total of a £1.8 million deficit in 2016/17 presented a significant risk due to the requirement to deliver cost improvement savings of £6.7million. A focussed approach to delivering the required savings whilst ensuring the provision of safe services was taken. The savings were delivered and the Trust delivered a year end out turn figure of £1.1m deficit but some of the savings have been delivered on a non-recurrent basis. The return to a financially sustainable position remains a risk to the Trust.

The lack of access to care in the community increases the number of delayed transfers of care experienced by the Trust. The work with partner organisations has progressed significantly during 2016/17, but is yet to realise a notable reduction in delays. Schemes have included implementation of Support at Home service in partnership with the Red Cross, a pilot scheme for enhanced support for self-funders and a pilot at Queen Charlotte Nursing Home commenced on 1st February 2017 for step-down assessment for long term care.

For 17/18 both financial sustainability and the Ophthalmology service remain key risks for the Trust. The Trust is also beginning to report risks in respect of medical staffing (ENT, Emergency Department and Gastroenterology)

The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that materially impact on patient safety. However, the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has a greatest appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, with the constraints of the regulatory environment.

The Director of Nursing and Quality is the executive lead for quality governance, supported as appropriate by the Medical Director and the Chief Operating Officer. The Board receives a regular Integrated Performance Report in which areas of good practice, issues of concern, and performance against quality metrics are reported. The Board also review specific examples of patient feedback both positive and negative at each meeting with a view to ensure that appropriate action is taken to safeguard quality and the patient experience and that learning is embedded throughout the organisation.

The Quality Committee scrutinises the detail of quality governance in the organisation and provides additional assurance to the Board. The Quality Committee meets monthly and receives key regulatory and other inspection reports and scrutinises the delivery of associated action plans. The committee also carries out “deep dive” reviews of any aspects of quality that are causing concern

The Finance and Performance Committee meets monthly and includes the detailed monitoring of all national and local performance targets within its remit. Many of these indicators contain quality components, for example, cancer standards, emergency department indicators, infection control trajectories and levels of cancelled operations.

The Board is actively engaged in quality improvement and is assured that quality governance is subject to rigorous challenge through Non-Executive Director engagement and Chairmanship of the key board committees.

The revised Information Strategy (approved by the Finance and Performance Committee and Senior Management Team in December 2016) recognises data quality as one of the five core elements of the Information Maturity Model. As we gradually move towards a paper light NHS, information is becoming a more integral part of the routine processes used to deliver healthcare across the organisation. Therefore, excellent data quality is pivotal in order to ensure that the data from different systems can be seamlessly joined together and provided to healthcare professionals in a timely, secure and accurate fashion. Specific actions have been taken to strengthen the existing processes around data quality over the last few months, building on the data quality processes and procedures that have been in place for some time the Trust. Current processes and procedures as well as recent initiatives to improve data quality include the following:

- **Information Assurance:** The Data Quality Management Group has provided a robust mechanism to monitor and control data quality measures for the clinical Information Systems. This group has been re-formed into an Information Assurance Group that will extend data quality assurance to cover all aspects of data quality within the Trust including the data items reported on the Trust dashboards.
- **Governance.** Governance improvements around the Information Assurance Group have been made in order to allow other Groups such as the Clinical Coding Task and Finish Group and the Clinical Informatics Group to escalate all data quality issues to Information Assurance Group. Finally, bi- monthly highlight reports to Health Informatics Programme Board will provide appropriate visibility on any major data quality issues.
- **Information Dashboards.** Performance Dashboards have been reviewed and appropriate improvements have been implemented. Work on developing a Data Quality Dashboard has commenced.
- **Regular audit and external assurance.** Audits and in-depth analysis of data quality are conducted in a number of areas, including: mortality; specialist clinical coding areas (on a regular, randomly selected basis as per national best practice recommendations in addition to departmental clinical audits. Key issues will be discussed at the Information Assurance Group to ensure a culture of continuous improvement on data quality.
- **Information Systems.** As more information is captured in our information systems and business processes change accordingly, it is important to understand the data quality implications from any systems change. The Information Assurance Group

has been working closely with the system managers and the key business users to address any data quality issues.

A Care Quality Commission (CQC) inspection was undertaken at the Trust during March 2016 with inspectors assessing eight core services as part of the planned inspection programme. All areas received a rating of 'good' for the 'caring' domain with services for children and young people received particular praise, achieving 'good' for all of the areas assessed.

The Trust was rated as 'good' for four services overall: children and young people, medical care, surgery and critical care. Four services were rated as 'requires improvement': urgent and emergency services, maternity and gynaecology, end of life care and outpatients and diagnostic imaging. In total, inspectors found 25 out of the 39 factors they assessed 'good' – 64%. Overall the Trust was rated overall as 'requires improvement'.

The action plan to address the recommendations in the report was agreed by the Board and progress is monitored on a monthly basis by the Quality Committee. In addition, as part of the internal audit programme, KPMG have been asked to undertake work to test the implementation and sustainability of the actions identified.

In its 2015/16 Annual Report the Trust reported risks in compliance with the NHS Foundation Trust Licence condition 4 (FT Governance) in relation to Divisional and Service Level governance arrangements. During 2016/17 the Board has conducted a review of the effectiveness of the Trust's system of internal controls. The Trust has undertaken both an organisational review and a review of governance arrangements with a particular focus on Divisional and Service level. The Trust is due to implement its new organisational structure and governance framework from 1 April 2017

The Trust is able to assure itself of the validity of its Corporate Governance statement as required under NHS Foundation Trust Licence condition 4 through the following mechanisms that have been deployed during 2016/17

- the Board has maintained a strong emphasis on quality in its meeting agendas to ensure that quality is the focus of decision making and planning;
- the Board has an executive lead for quality and clear accountability structures are in place for a quality agenda that is integrated into all aspects of the organisation's work;
- the Board carries out visits to wards to meet with staff and patients and gain feedback. The governors also carry out assurance visits;
- the Board has driven and overseen delivery of the 2016/17 Operational Plan, demonstrating that the Trust can operate with efficiency, economy and effectiveness;
- the Board has maintained appropriate oversight of regulatory and inspection regimes including that of NHS Improvement, the Care Quality Commission and the HRA and has monitored the management of gaps where any have been identified. The Board

encourages close working with regulators and inspectors to ensure that all requirements are met and quality standards are maintained at the highest level; and

- the Board Assurance Framework has been regularly reviewed by the Board to ensure focus on the key risks to delivery of the organisation's principal objectives.

The Trust involves its stakeholders in managing risk in the following ways:

- regular reporting to the council of Governors on quality, finance and performance, with an emphasis on the reporting of risks, current concerns and complaints;
- attendance of Governors at key meetings including Quality Committee, Audit Committee, Finance and Performance Committee and Clinical Governance Committee;
- regular contract meetings with the Trust's principle commissioners to review performance against and risks relating to delivery of the contract;
- consulting with its membership on key strategic direction decisions and any proposed major changes in service delivery;
- regular attendance at and presentations as required to the local Overview and Scrutiny Committee meetings; and
- joint working with other local and regional healthcare providers to shape optimum care pathways and mitigate risks.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

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

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

The Trust produces detailed annual plans reflecting its service and operational requirements and its financial targets in respect of income and expenditure and capital investments. The plan incorporates the Trust's plan for improving productivity and efficiency in order to



minimise income losses, meet the national efficiency targets applied to all NHS providers and fund local investment proposals. Financial plans are approved by the Board, having been previously assessed by the Finance and Performance Committee.

The in-year resource utilisation is monitored by the Board and its committees via detailed reports covering finance, activity, capacity, workforce management and risk.

The board is provided with assurance on the use of resources through a regularly integrated performance report. The Finance and Performance Committee also undertakes a detailed review on a monthly basis. External auditors review the use of resources each year as part of the annual audit programme. Internal audit resources are directed to areas where risk is attached or where issues have been identified. Any concerns on the economy, efficiency and effectiveness of the use of resources are well monitored and addressed in a timely and appropriate manner.

The external auditors have reviewed our use of resources and concluded that: 'we are satisfied that, for two out of three areas (partnership working and informed decision making), the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017. However, the deteriorating financial position and particularly the increased scale of the forecast deficit for 2017/18 does impact upon the Trust's ability to plan finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.'

The Trust accepts that this is the current position but anticipates that a longer term solution will be provided through the implementation of the Trust's Strategy which includes working towards integrated models of care and the Dorset Clinical Services Review.

### **Information Governance**

The Trust operates under the Guidelines and Legislation which govern Information Governance within the NHS and have embedded the processes necessary to meet the standards required and have submitted a 'Satisfactory' Information Governance Toolkit score of 87%. Our Information Risk Management Policy and Risk Management Structure is owned by the Trust's Senior Information Risk Owner and reviewed via the Information Governance Committee. The Trust has an Information Security Policy which details the security arrangements in place for systems and devices.

The Trust reported three incidents to the Information Commissioner's Office during the 2016/2017 year. The first of these incidents occurred at a third party site who suffered a breach in their information security systems which allowed information pertaining to some of the staff at the Trust to be accessed by a further third party. The Trust's Information Security arrangements were not compromised and the information held on the Trust's systems was not at risk. The second serious incident involved a member of staff accessing information which they were not entitled to access. The third incident occurred when the email addresses of all Foundation Trust Members was shared with all of the members in error. No sensitive or confidential information was inadvertently shared, only the email addresses themselves. Each of the above incidents have been shared with the Information Commissioner who has not imposed any sanctions.

Once the investigations have been closed these incidents will be published by the Information Governance Toolkit amongst their quarterly reports of all Level 2 Serious Incidents.

### **Annual Quality Report**

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Trust's Quality Accounts priorities for each year are selected following consultation with the Board, Council of Governors, clinicians and other relevant parties. Priorities that will require implementation over a period of years are carried forward into the following year. The Director of Nursing and Quality is the executive lead for the Quality Accounts and preparation of the Quality Report. The Trust's policies, procedures and clinical guidelines provide a robust foundation for and support the delivery of quality care. All policies, procedures and guidelines are stored on databases that are centrally co-ordinated to ensure the documents are kept up to date and only current versions are available to staff.

Data collected to provide assurance of progress against priorities comes from a range of sources both internal and external. These include clinical audit, the VitalPac system, falls risk assessments, the Global Trigger Tool, performance metrics and national patient and staff surveys. Both the CCG and Dorset County Council Health oversight and Scrutiny Committee provide assurance of the accuracy of this data. KPMG, as internal auditors, also provide scrutiny of data quality and Key Performance Indicators (including elective waiting time data) and this year have evaluated both falls data and ambulance handover times. The outcome of this assessment has been 'significant assurance (the highest level of the four categories)'. The data is used to provide both the Quality Committee and the Board with quarterly reports on progress against the selected current year Quality Accounts priorities and to identify trends and any issues of concern. The Quality Committee is an assurance committee which provides scrutiny of the Quality Report for the Board.

The Trust uses the same systems and processes to collate, validate, analyse and report on data for the annual Quality Report as it does for other clinical quality and performance information. The data is subject to regular review and challenge at speciality, Divisional and Trust levels. This information is quality assured by subcommittees of the Trust Board, chaired by a non- executive Director prior to providing either assurance or exception to the full Trust Board. The information is also analysed and discussed at the divisional performance and governance meetings, chaired by the Divisional Directors and attended by the multi-disciplinary clinical teams. Full reports are also provided to the Clinical Commissioning Group on a monthly basis, and discussed at the Contract Monitoring Meetings and Quality meetings monthly.

The Trust Quality Report is shared with key stakeholders including the Council of Governors, Dorset CCG, Dorset County Council Health Scrutiny Committee and HealthWatch Dorset, all of whom are invited to comment.

The Quality Report for 2016/17 is subject to External Audit.

### Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust continually seeks to improve the effectiveness of its systems of internal control and put action plans in place to meet any identified shortfalls. The Board agenda concludes with a reflection session on the conduct of each board meeting. The Board undertook a self-assessment of its effectiveness at the end of 2016/17. Self-assessments of effectiveness have also been undertaken by the audit Committee, Quality Committee and Finance and Performance Committee. Trust Board meetings are open to members of the public and Board Committees are attended by nominate governor observers. The Board reporting cycle ensures that the Board received regular reports from its Committees, operational report from Executives, the Assurance Framework and Risk Register bimonthly and planned reports on business and other operational issues.

The governance structure is as follows:

**The Board:** The powers reserved to the Board are, broadly, regulation and control; strategy; business plans and budgets; risk management; financial performance and reporting and audit arrangements.

**Audit Committee:** Provides assurance to the Board as to the effectiveness of the Trust's systems of governance and control across the full range of the Trust's responsibilities. It reviewed the establishment and maintenance of an effective system of integrated governance, risk management, finance, counter fraud, security management, and internal control across the whole of the organisation's activities, both clinical and non-clinical. It utilises the assurance framework, risk register, internal and external audit reports, the work of the Quality committee and the ability to question the Chief Executive regarding the Annual Governance Statement to support its work.

**Finance and Performance Committee:** Provides assurance to the board and does not remove the requirement for the Board to monitor financial, operational and workforce performance. The committee provides scrutiny and makes recommendations to the Board

to assist in decision making. Specific areas scrutinised by the Finance and Performance Committee include financial planning, operational performance, workforce, business case assessments and the delivery of efficiency and cost improvement programmes. The Finance and Performance Committee is able to approve business cases within delegated limits.

**Quality Committee:** provides assurance that the Trust has an effective framework within which it can work to improve and assure the quality and safety of services it provides in a timely, cost effective way. The Committee assesses reviews and monitors performance, internal control, external validation and assessment, annual report and plans and national guidance and policy.

My view is further informed by:

- Opinions and reports by Internal Audit, who work to a risk based annual plan. The Head of Internal Audit Opinion for 2016/17 was as follows:  
  
‘Significant assurance with minor improvement opportunities’ can be given on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.”
- Opinion and reports from the Trust’s External Auditors
- Monthly reports to NHS Improvement
- Full compliance with the Care Quality Commission essential standard for quality and safety for all regulated activities across all locations
- Results of patient and staff surveys
- Investigation reports and action plans following serious incidents
- Council of Governors Assessment Team Reports
- Clinical audit reports

### Conclusion

No significant internal control issues have been identified for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Patricia Miller  
Chief Executive  
22 May 2017

The Accountability Report was approved by the Board of Directors on 22 May 2017 and signed on its behalf by

Patricia Miller  
Chief Executive  
22 May 2017

## Quality Report

### Part 1 – Quality Accounts and Approach to Quality

#### What is a Quality Account?

Every NHS trust is required to produce an annual report and annual accounts. Within the annual report, there is a chapter which reports on our annual quality accounts, and these quality accounts are also published on [NHS Choices](#).

NHS foundation trusts, such as Dorset County Hospital, have to submit these to Parliament and to our independent regulator, NHS Improvement. This happens in July each year and the reports are also published on our website.

The quality accounts are intended to allow people to compare the performance of different trusts as we are all required to report on the same things. They contain the quality priorities that we set for our hospital and services, and report back on our progress in achieving the priorities that we set ourselves last year.

Dorset County Hospital (DCH) has delivered significant amounts of change to improve both the effectiveness and the quality of its services during 2016/17.

Working in conjunction with our clinical staff, DCH has been able to make changes to patient pathways in support of the on-going work within the Vanguard, the Sustainability and Transformation Programmes and through the Clinical Services Review.

The following report does not reflect the additional improvement's that have been made, but does report on the nine Quality account priorities that were selected for inclusion in 2016/17. This report covers the period of April 2016 – March 2017

- There has been a significant reduction (57% of all grades) in the total number of Hospital Acquired Pressure Ulcers.
- The number of Electronic Discharge Summaries sent within 24 hours has not significantly improved and this quality account priority continues into the forthcoming year 2017/18.
- There has been an improvement in Sepsis screening, although this has not reached the standard required. This remains a quality account priority for the forthcoming year.
- Timeliness of complaint responses continues to cause concern. A remedial action plan has been developed in conjunction with the divisions. This remains as a quality account priority for 2017/18.
- The nine Quality Account priorities have been selected (and previously agreed by the Quality Committee) for the forthcoming year 2017/18 and are detailed within the report.
- The local indicator for inclusion by the governors has been selected as the '28 day readmission' indicator.

## Our Approach to Quality

As part of the standards for patient services detailed within the NHS Constitution and the Care Quality Commissions' ('CQC's') fundamental standards of quality and safety, the Trust is committed to the provision of safe, high quality care and achieving a good or outstanding CQC rating.

In 2016, the Trust commissioned an independent review of its governance processes which has highlighted the need for more structured visibility of quality and safety metrics from 'Ward to Board'. The Trust is currently in the process of implementing a mechanism for the display of this data to provide assurance at both divisional and executive level.

The Quality Account priorities 2017/18 have been selected by the Trust. These build on the recommendations detailed within the independent reviews as well as reflecting the National and Local commissioning needs and the top risks to quality identified internally.

## Statement on Quality from the Chief Executive

It gives me pleasure to introduce our Quality Account for Dorset County Hospital NHS Foundation Trust (The Trust). I am delighted to share the progress and achievements our staff have made during 2016-2017 in conjunction with our patients and stakeholders.

This account will not only detail the progress made against the priorities set for last year, but will also detail the priorities that we, in collaboration with our patients and our colleagues at the Local County Council and Clinical Commissioning Group, have committed to deliver for the forthcoming year 2017-2018.

Although the vision for the Trust is being developed, it is committed to providing Delivering Safe, Effective and Compassionate Healthcare to all those who use our services. This means delivering excellent clinical outcomes in a caring, compassionate and safe environment. This has been endorsed by the Care Quality Commission this year, which rated the Trust as GOOD in the Caring domain, and in 4 out of the 8 core services of their inspection framework.

We believe that we have very largely achieved our objective of delivering safe, effective and compassionate healthcare but we are a learning organisation which strives to learn lessons when our care does not meet your expectations, implementing changes to improve standards. This is done through a variety of methods; detailed investigations of occasions where the quality and or safety of care given to our patients has been compromised. These are presented to our 'Learning from Incident Panel' to ensure the learning is spread around our teams. We review all complaints and patient experience at our 'Learning from Patients Committee' and through 'patient safety walk arounds' undertaken by our Board members and patient representatives. Learning from these is communicated to our staff in our weekly Chief Executive's Brief.

We are proud of our culture of compassionate care, supported by both our Trust Values and Patient Charter - with the underlying characteristics of *Excellence, Integrity, Teamwork and Respect*. These are the values that our staff, patients and stakeholders told us were the most important to them.

I am pleased to confirm that the Board of Directors has reviewed the 2016-2017 Quality Account and confirm that it is an accurate and fair reflection of our performance. We hope that this account will provide you with a clear picture of the improvements we have made, the areas in which we know we will need to enhance further and the true sense of commitment that the Trust has to quality improvement, patient and staff safety, and patient and carer experience.

Finally, I would like to thank the staff at the Trust who work tirelessly every day to ensure that our patients receive the care they need. We recognise the significant contribution individuals and teams make to continually developing and improving the services we provide to our patients and community. I would also like to thank our patients and their families. Without their willingness to share their experiences with us we would not be able to make the improvements that we do.

Patricia Miller  
Chief Executive  
22 May 2017



## Part 2 – Our Quality Priorities

### Priorities for Improvement 2016-2017

Every year we develop our priorities for the forthcoming year following engagement with our clinical staff, our partners, our patients and their families.

Last year, we set our priorities:

#### **Patient Safety:**

- Zero tolerance to Hospital Acquired Pressure Ulcers
- Improved Mortality Surveillance and Reducing Variation
- Reducing the Incidence of Severe Sepsis and managing patients effectively when admitted with this condition

#### **Clinical Effectiveness:**

- Implementation of improved discharge processes
- Increase in the percentage of Electronic Discharge Summaries (EDS) sent within 24 hours and meeting the quality requirements agreed with Primary Care
- Improving availability and Accessibility of Information to Patients

#### **Patient Experience:**

- Improving Services for patients with Learning Disabilities
- Advanced Communication skills for staff supporting those at the End of Life
- Timely and Compassionate Response to Complaints

These priorities are reported on section three of this report.

Quality Achievements 2016/17

**Patient Safety**

**Sustained 10% reduction in Hospital  
Acquired Pressure Ulcers**

**Improved screening of patients with  
possible sepsis**



**Clinical Effectiveness**

**Sustained Certification against the  
'Information Standard'**

**Effective use of resources to improve  
discharge**



**Patient Experience**

**Improved awareness and services for  
Patients with Learning Disabilities**

**Bespoke communication skills training for  
staff supporting those at end of life**



## Priorities for Improvement 2017-2018

These priorities are based on themes of complaints, concerns raised, incidents which have occurred in the trust, feedback from the friends and family test and national surveys which identify the areas in which the trust needs to develop its services further. These are shared and agreed with our local commissioners and our Local authority colleagues at the Health Overview and Scrutiny Committee.

We have therefore set the following priorities for the forthcoming year:

### **Patient Safety:**

- Reducing avoidable harms from Hospital Falls
- Improved Mortality Surveillance and Reducing Variation
- Improving early identification and treatment of Sepsis

### **Clinical Effectiveness:**

- Improving the support from Hospital Volunteers to have positive effects on clinical outcomes (Loneliness Agenda)
- Increasing the percentage of Electronic Discharge Summaries (EDS) sent within 24 hours
- Promoting the Health and well-being of both patients and staff

### **Patient Experience:**

- Improving the identification, assessment and referral for patients with Dementia
- Timely and Compassionate Response to Complaints
- Improving accessibility of information to our patients

## Statement of Assurance from the Board

1. During 2016 – 2017, The Trust provided and/or subcontracted 35 relevant health services.
- 1.1 The Trust has reviewed the data available to them on the quality of care in all of these relevant services.

- 1.2. The income generated by the relevant health services reviewed in 2016 – 2017 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2016 – 2017.
2. During 2016 - 2017 40 clinical audits and 6 national confidential enquiries covered relevant health services that the Trust provides.
  - 2.1 During that period the Trust participated in 95% National Clinical Audits and 100% National Confidential Enquiries which it was eligible to participate in.
  - 2.2 The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2016- 2017 are as follows:
  - 2.3 The national clinical audits and national confidential enquiries that the Trust participated in during 2016- 2017 are as follows:
  - 2.4 The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2016- 2017, are listed below alongside 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.

## National Clinical Audits

The NHS England-funded National Clinical Audit and Patient Outcomes Programme (NCAPOP) are a mandatory part of NHS contracts, and as such we are required to participate in those that relate to services provided by this Trust. The following table describes the audits we have participated in, and the relevant compliance.

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	21	123%
Adult Asthma (BTS)	Y	N	Insufficient numbers to participate.	
Asthma (paediatric and adult) care in emergency departments (RCEM)	Y	Y	51/50	102%
Bowel Cancer (NBOCAP)	Y	Y	135	100%
Cardiac Rhythm Management (CRM)	Y	Y	348	Ascertainment rate pending
Case Mix Programme (CMP)	Y	Y	776	100%

## DCHFT Annual Report and Accounts 2016/17

Child Health Clinical Outcome Review Programme		Y	Y	5	100%
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		Y	Y	323	119%
Diabetes (Paediatric) (NPDA)		Y	Y	93	100%
Elective Surgery (National PROMs Programme)		Y	Y	2017-17 data released August 2017	
Endocrine and Thyroid National Audit		Y	Y	11	100%
Falls and Fragility Fractures Audit programme (FFFAP)	Hip Fracture Database	Y	Y	312/326	95.71%
	Fracture Liaison Service	Y	Y		Ascertainment figures pending
	Falls	Y	N	Audit not running 2016-17	
Head and Neck Cancer Audit		Y	Y	PGH	PGH
Inflammatory Bowel Disease (IBD) programme		Y	Y		Ascertainment figures pending
Learning Disability Mortality Review Programme (LeDeR Programme)		Y	Y	3	100%
Major Trauma Audit (TARN)		Y	Y	218 (Q1/2/3 2016)	Ascertainment rate pending
Maternal, Newborn and Infant Clinical Outcome Review Programme		Y	Y	31	100%
National Audit of Dementia		Y	Y	46	100%
National Cardiac Arrest Audit (NCAA)		Y	Y	75 (pending report July 2017)	100%
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Audit		Y	Y	27	100%
National Comparative Audit of Blood Transfusion - Audit of Patient Blood		Y	Y	2	100%

## DCHFT Annual Report and Accounts 2016/17

Management in Scheduled Surgery					
National Diabetes Audit - Adults		Y	Y	6039	100%
National Emergency Laparotomy Audit (NELA)		Y	Y	149	95.97%
National Heart Failure Audit		Y	Y	136	Ascertainment rate pending
National Joint Registry (NJR)	Hips	Y	Y	360	94%
	Knees			312	94%
	Shoulders			24	77%
	Elbows			3	100%
	Ankles			2	100%
National Lung Cancer Audit (NLCA)		Y	Y	110	100%
National Ophthalmology Audit		Y	Y	0/1342	0%
National Prostate Cancer Audit		Y	Y	270	100%
National Vascular Registry	AAA	Y	Y	4	100%
	IIB			36	100%
	Amputation			87	100%
Neonatal Intensive and Special Care (NNAP)		Y	Y	235	100%
Nephrectomy audit		Y	Y	Figures released later this year	
Oesophago-gastric Cancer (NAOGC)		Y	Y	46	100%
Paediatric Pneumonia		Y	Y	13	100%
Percutaneous Nephrolithotomy (PCNL)		Y	Y	Figures released later this year	
Radical Prostatectomy Audit		Y	Y	Figures released later this year	
Renal Replacement Therapy (Renal Registry) (**figures for 2015, most recent)		Y	Y	679	100%

*Rheumatoid and Early Inflammatory Arthritis	Y	N	0	0
Sentinel Stroke National Audit programme (SSNAP)	Y	Y	408	100%
Severe Sepsis and Septic Shock – care in emergency departments (RCEM)	Y	Y	50/50	100%
**Stress Urinary Incontinence Audit	Y	N	0	0
UK Cystic Fibrosis Registry	Y	Y		Ascertainment figures pending
Consultant Sign-Off (RCEM)	Y	Y	110/50	220%
Smoking Cessation	Y	Y	228	152%

\*Insufficient resource to participate, pending appointment of new clinician

\*\*Procedures carried out by Uro-Gynae team at DCH- audit run by British Association of Urological Surgeons (BAUS), therefore DCH not participating.

### **National Confidential Enquiries into Patient Outcome and Death (NCEPOD)**

NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

<b>Name of Audit</b>	<b>Trust Eligible</b>	<b>Trust Participation</b>	<b>Cases Submitted</b>	<b>% of Registered Cases</b>
Mental Health	Y	Y	4	
Acute Pancreatitis	Y	Y	6	
Acute Non Invasive Ventilation	Y	Y	5	
Chronic Neurodisability	Y	Y	ongoing	
Young People's Mental Health	Y	Y	ongoing	
Cancer in Children, Teens and Young Adults	Y	Y	ongoing	

<b>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</b>	<b>This year the reports published are:</b>
	<b>National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)</b> –report published Nov 2016
	<b>Treat the Cause – A review of the quality of care provided to patients treated for acute pancreatitis</b> – We are already compliant with many of the recommendations including a formal arrangement with the tertiary specialist unit at Southampton and a network video-linked MDT. We also have a well-established MEWS for identification of deteriorating patients. Although we were already aware of the recommendation for early definitive surgery, this is difficult to accomplish for all patients due to theatre capacity, time and resource.
	<b>NCEPOD Lower Limb Amputation Working Together Document</b> - Our service is part of a modern clinical network with our hub service providing many of the rehabilitation and specialist physio and OT services. Our patients at DCH have full access to this. Our job plans allow for review of patients with acute diabetic foot disease within 24 hours of admissions. A multi professional team see all diabetic foot patients throughout the week including a dedicated MDT; multiprofessional outpatients and ward round on the DCH site. It is in place that all major amputations will be performed at our hub site from January 2017 onwards.
	<b>Chronic Neurodisability study</b> - This study focuses on cerebral palsy. DCH will provide a summary of local actions once the report has been published
	<b>Treat as One</b> - Bridging the gap between mental and physical healthcare in general hospitals

The reports of 32 National Clinical Audits were reviewed by the provider in 2016- 2017.  
The table below summarises the audit outcomes:

<b>Name of audit / Clinical Outcome Review Programme. Report publication date</b>	<b>What this Trust knows</b>
<b>Bowel cancer (NBOCAP) Dec 2016</b>	Overall, data quality is excellent for this Trust, although a single area (pre-treatment TNM documentation) can be improved (we achieve 74% documentation which is higher than the regional or national level). Rates of laparoscopy were very high for resectional surgery (75%). This is well above the national rate of 61%. Low rates of hospital stay over 5 days were achieved (56% vs 69% national). 90 day mortality, 2 year survival and 30 day readmission rates were within normal limits and similar to network data. The trust has a low rate of 18 month stoma rate.



<b>Cardiac Rhythm Management (CRM) Aug 2016</b>	DCH continues to have an Implant rate that is considerably above average UK performance for all cardiac rhythm devices. Our physiological pacing is 100%.
<b>Case Mix Programme (CMP) (ICNARC) Dec 2016</b>	The results of this audit continue to be good
<b>Child health clinical outcome review programme</b>	There have been no themed reports from this programme this year
<b>Coronary Angioplasty/National Audit of PCI April 2016</b>	DCH submits 100% of our percutaneous coronary intervention procedures into this audit. Our data completeness is excellent apart from the recording of serum creatinine in the database (it is checked prior to all procedures). We have excellent door to balloon times for primary PCI Our use of radial access for PCI is higher than national average.
<b>Diabetes (Paediatric) (NPDA) Feb 2017</b>	<p>The report provides reassurance of good standards of paediatric diabetes care, evidenced by our high rankings both regionally and nationally for completing care processes and achieving low HbA1c levels.</p> <p>This year there were issues centrally around publication of lipid profile data and Thyroid and Coeliac figures in the national report. Will has approached the central team to address these problems. Our locally held data provides assurance that our profile in these missing fields are in line with or better than national figures.</p> <p>Our good levels of performance provide support for our model of annual screening and individual structured education and other Trusts may learn from our model</p>
<b>Elective surgery (National PROMs Programme) Feb 2017</b>	This Trusts PROM results are not made available to the Clinical Audit Group. The nominated leads are responsible from review of PROMs outcomes. The orthopaedic consultants have provided assurance that DCH is not an outlier in any of the areas measured.
<b>Endocrine and Thyroid National Audit Jan 2017</b>	Our service is well within the expected benchmarks. There are no areas of concern. Local surgeon results are reviewed annually at the regional thyroid SSG.
<b>Falls and Fragility Fractures Audit Programme (FFFAP) April 2017</b>	<p>National Hip Fracture Database Report - The format of this report has now changed and results are presented as a traffic light system (green = top 25% red bottom 25%). DCH is in the top 25% in the majority of indices. Of note we are the second best trust nationally in terms of best practice tariff in the South West of England. We have a very high level of patients receiving surgery after admission.</p> <p>The second round of the National Audit of Inpatient Falls has been delayed until May 2017.</p>
<b>Inflammatory Bowel Disease (IBD) programme Sept 2016</b>	The Biologics report was published in Sept 2016 –The Gastroenterology team have been asked to review this report on behalf of the Trust

Learning Disability Mortality Review Programme	New – no report published yet
Lung cancer (NLCA) Jan 2017	DCH are at or above national averages for: stage completeness; active anti-cancer treatment; patients receiving surgery; patients receiving chemo; and 1 year survival rates. We are less than national average for performance status completeness; percentages of patients discussed at MDT; pathological diagnosis; percentage of patients seen by the Specialist Nurse; and NSCLC patients having chemotherapy.
Major Trauma: The Trauma Audit & Research Network (TARN) Quarterly report structure	These results are reviewed quarterly by the Major Trauma Review Committee.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) May 2016	Publications from this project are reviewed by the Maternity Forum. The 2015 report highlighted the urgent need to improve training of relevant professionals about perinatal mental illness and the speed at which illness can progress. The UK Perinatal Mortality Surveillance Report shows an overall reduction in rates of stillbirth and neonatal death.
National Cardiac Arrest Audit (NCAA) Quarterly report structure	Data is published quarterly and is reviewed by the Resuscitation Committee. This committee is responsible for action planning and follow up of actions
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme Feb 2017	This is changing from a snapshot audit to continuous data collection from February 2017. The respiratory team lack the resource to do this but will be supported by the Audit Department. This issue has been escalated to SMT. A report was published in January 2017 and the Respiratory Audit Lead has been asked to review
National Comparative Audit of Blood Transfusion programme Aug 2016	The 2016 Audit was entitled Red Cell and Platelet Transfusion in Adult Haematology Patients – this report was reviewed by the Hospital Transfusion Committee in Jan 2017.
National Diabetes Audit – Adults Mar 2017 Foot Care report	There is a pathway in West Dorset for the management of diabetic foot ulcers and there is good coordinated working with DHUFT to provide this. There is a DCH multidisciplinary team with an established record of team-working. However, there are some areas of concern: <b>Podiatry provision:</b> Lack of inpatient podiatry at DCH for diabetic patients with foot ulceration has been highlighted in the recurrent national diabetes inpatient audits over the last 5 years. This gap in the service jeopardises the link between inpatient and outpatient care. DCH has agreed the services of a podiatrist for <i>outpatient work only</i> , however this is also only for 42 weeks of the year. <b>Time to MDT triage:</b> NICE guidance recommends that all patients who are referred are triaged by the multidisciplinary team within 48hours. At DCH only 5/79 (6%) patients were seen within 2 days. Nationally the figure was 14%. Nationally as many as 40% of patients were seen 14 or more days after referral. At DCH the figure was 50/79 (63%). The number of referrals to DCH has been increasing year on year and community investment in prevention has

	<p>not led to a reduction in the incidence of ulcers. The waits to be seen are acutely exacerbated by the lack of 52 week podiatry cover.</p> <p>The NDFA showed that the longer the wait to first assessment the less likely that the patient will be ulcer-free at 12 weeks. In the NDFA, ulcer-free rate fell from 50% to 43% if time to first assessment was &gt;14 days. DCH has a very high proportion of patients seen &gt;14 days from referral hence risking toe or leg amputation.</p>
National Diabetes Audit (2015-2016) - Report 1: Care Processes and Treatment Targets	<p>This report was published in Feb 2017 – we are awaiting a local action plan</p>
National Emergency Laparotomy Audit (NELA) July 2016	<p>DCH outcomes in this report are similar or better than national averages in most areas: We fall below national average for the following standards: proportion of patients who had a CT scan performed before emergency laparotomy (78% against a national figure of 83%); proportion of patients for whom surgery was directly supervised by a consultant surgeon and a consultant anaesthetist if pre-operative p-possum mortality risk <math>\geq 5\%</math> (64% against a national figure of 74%). We are well below the standard target for Elderly Medicine reviews (7%) but this is in keeping with the national average (10%). There are no plans in place to improve this. It has been accepted by divisional leads that this is not currently achievable and is not a priority for the Trust.</p>
National Heart Failure Audit July 2016	<p>DCH is below the minimal level of data entry for this audit (65% of patients against the expected 70%) – work is being done to address this. Work is also being done around coding of patients to correctly identify the patients for this audit and improve the quality of data submitted. This is important as it may impact on payment of best practice tariff. We have improved on the % of patient's being seen by HF specialist and we have improved on the % of patient's being prescribed key disease-modifying drug treatments.</p>
National Joint Registry (NJR) Sept 2016	<p>DCHFT is not an outlier for <u>any</u> of the parameters in this report. However, there have been recent problems with data submission and quality; this is an administrative problem</p>
National Ophthalmology Audit May 2016	<p>The report was published in May 16. This was a pilot report so no actions are anticipated for the Ophthalmology team</p>
National Prostate Cancer Audit Dec 2016	<p>DCHFT is fully compliant with this audit (our results are logged under Royal Bournemouth as this is where procedures are carried out).</p>
National Vascular Registry Nov 2016	<p>DCH has excellent clinical outcomes; is fully compliant with national specifications; has low levels of Angioplasty data recorded</p>

<b>Neonatal Intensive and Special Care (NNAP) Oct 2016</b>	This report was published in Oct 2016. The Paediatric Lead has been asked to review
<b>Oesophago-gastric cancer (NAOGC) Sept 2016</b>	This national report does not give Trust level mortality rates for us, as all resections are carried out at the Specialist Centre (Bournemouth). A regional action plan has been developed by the MDT and is reviewed by them.
<b>Renal replacement therapy (Renal Registry) Dec 2016</b>	This Trust continues to upload data to this registry. A report is expected later this year. A comprehensive renal audit programme is run by the renal team
<b>Rheumatoid and Early Inflammatory Arthritis July 2016</b>	Due to staffing levels we were unable to upload data to this national audit. However, the Specialist Nurse has reviewed the national report on behalf of the Trust and compared local provision against the national data. We comply with recommendation for service provision in all areas except access to same day ultrasound. Although we do not have local data we are compliant with most local provider outcomes. However, seeing patients within the recommended 3 weeks of referral is dependent on full consultant staffing levels.
<b>Sentinel Stroke National Audit Programme (SSNAP) Quarterly report structure</b>	Since receiving Level 'E' level (lowest level) rating in March 2016 the Stroke Steering Group has undertaken a number of measures to improve stroke services. The success of these measures is evidenced in the quarterly report published in August 2016 where we have achieved improvements in the levels for almost all of the parameters. The stroke service and partners are continuing to work on the improvements and sustainability of stroke performance. In particular, the measure '% of stroke patients who spend at least 90% of their stay on the stroke unit'. This work is closely linked with the Vanguard Programme a partnership arrangement between the three acute hospital Trusts in Dorset to deliver high quality and equitable care for Stroke patients across Dorset.
<b>Severe Sepsis and Shock care in ED (CEM)</b>	No report published yet.
<b>UK Cystic Fibrosis Registry</b>	No report published yet.

The reports of 96 number local clinical audits were reviewed by the provider in 2016 – 2017. A selection of these is catalogued below, and the Trust intends to take the following actions to improve the quality of healthcare provided:

## Local Clinical Audits

Local audits are carried out by the specialties in relation to areas of their work. These may be re-audits of past work, new services, audits relating to risk or service evaluations. 234 local audits were registered during 2016-17 and work will continue to see these through to completion.

Name of Audit	Finding	Outcome
3628 - I-Communicator Audit (a system to notify referrers of urgent or serious unexpected findings in diagnostic imaging examinations) March 2016	The I-Communicator alert system was introduced in May 2015. This audit was carried out to ensure that the system is appropriately used by reporting clinicians and acknowledgement is rapid and appropriate by requestors.	The audit found that alternative flag options would provide further assistance to both those reporting and those receiving reports to enable prioritisation of actions and the feasibility of this is being investigated.
	This snapshot audit of 222 examinations found: that the allocation of flags varies within an acceptable scope of practice amongst reporting clinicians; acknowledgement of the alert was less than one calendar day after being sent; appropriate actions were undertaken in the cases where an alert had been placed by the reporting clinician.	It identified that the system is not used to flag antenatal ultrasound scans (but an appropriate alternative system is in place). However, the Diagnostic Imaging policy for the use of i Communicator will need to be updated.
	The audit therefore provides reassurance that the system is effective	A re-audit is planned
3764 – A re-audit of adequacy of completion of radiology request forms April 2016	A previous audit carried out in 2014 found that 10% of radiology request forms were not fully completed. Referrers were made aware of the issue and this re-audit was carried out to assess whether this has impacted on the completeness of requests. The audit found that, although improved, 4 %	This audit supports the case for swift implementation of Order-coms (an electronic requesting system) and a case has been put forward for this

	of the requests did not have an adequate description of the clinical question to be answered	
3646 and 3998 - Adherence to WHO checklist and consent forms in interventional radiology Nov 2015/Nov 2016	The initial audit carried out in Nov 2015 found that 82% of interventional radiology procedures have a properly completed WHO checklist and 66% have a properly completed consent form. Staff were educated regarding the importance of form completion and upload to CRIS. Despite this when re-audited in June 2016 there had been no improvement in the percentage of WHO checklists and consent forms completed.	The WHO checklist will be updated to include patient ID, request form and consent form check. A re-audit is planned
The accuracy of interpretation of emergency abdominal CT in adult patients who present with non-traumatic abdominal pain: results of a UK national audit	This national audit found clear benefits of CT interpretation/review by on-site and more senior (Consultant) radiologists. DCH has an onsite consultant delivered service. However, in future we will be outsourcing our on-call service and therefore we will need a robust system for reviewing outsourced imaging as soon as possible. Our error rate is better than the recommended RCR standard.	This audit provides reassurance that we are complying with best practice. If CT is outsourced or reported off site we will undertake early review that quality is being maintained.
3840 – A re-audit of hip neonatal ultrasound for suspected developmental dysplasia of the hip April 2016	An audit carried out in 2014 revealed a number of shortcomings in the hip neonatal sonography service not all patients were scanned within the target timeframes. As a result, a number of organisational changes were implemented and the current audit was carried out to	This audit shows a significant improvement in timeliness of scans and we now meet national targets. A re-audit is planned to ensure we maintain this improvement



	<p>assess the effectiveness of these changes. Although there were fewer babies requiring scans during this audit period, all met the national targets</p>	
<p>3786 - A review of initial and post-operative pain management of patients with fractured neck of femur (NoF) May 2016</p>	<p>This audit was carried out after physiotherapists raised concerns that patients with NoF may not be starting rehabilitation in a timely manner because of inadequate pain relief. The audit found that only 65% had administration of a fascia iliaca block (FIB) in the emergency department (ED). Although 86% of patients received regular postoperative paracetamol only 22% received regular/frequent PRN opiates. Although post-operative physiotherapy is being offered to 84% of patients in the first day post-surgery only 57% are receiving it. In many of these patients this was due to pain.</p>	<p>As a result of this audit the nursing staff have been educated on the use of the Abbey pain scale. Consideration will be given to introducing a NOF enhanced recovery pathway which will include up to date recommendations for pain relief pre and post-surgery. A re-audit is planned in 6 months' time</p>
<p>3696 - Physiotherapy Outpatients Department Osteoarthritis Knee Class 2016</p>	<p>This audit found that: 100% of patients receive education on self-management of OA knee as outlined in NICE guidance; over a third of patients improve over a 6 week period of participating in the class (as measured by KOOS score); there are still a number of people that do not attend all the sessions; over 50% of people do wait 8 weeks or more following a referral to the class.</p>	<p>Audit results shared with the team to improve appropriate referrals; regular classes will be organised in advance; an agreement will be sought from patients that they will attend all 4 sessions (they will be asked to signature on the referral document). A re-audit is planned in 12 months</p>
<p>4021 – A re-audit to explore whether pain is recognised</p>	<p>An initial audit carried out in Nov 2015 highlighted under recognised and under-treated pain was leading to</p>	<p>As a result of this audit: an education board (focusing on non-verbal signs of pain and the abbey pain scale)</p>

and adequately treated on Elderly care wards? Feb 2017	<p>delayed rehabilitation, increased length of stay and patient distress. Following the audit education sessions were provided to improve ward staff's awareness of non-verbal signs of pain and to encourage the staff to implement the abbey pain scale to increase their awareness of non-verbal signs of pain. This re-audit showed a significant improvement in staff being able to recognise the non-verbal signs of pain. However, the standards are still not being met in all areas</p>	<p>will be displayed on both Day Lewis and Barnes wards; therapists will begin to document the pain scale in written notes and use the abbey pain scale in MDT's/Board round; one to one training will be offered where required. A re-audit to explore rates of prescription and administration of analgesia is planned.</p>
3789 – Use of 'This is me' documentation of in Elderly Care Medicine Feb 2017	<p>This audit was carried out by the therapy team to look at compliance with dementia care pathway for those patients with a diagnosis of dementia and/or confusion. It audited against recommendations from the Alzheimer's Society and Dorset County Hospital's Dementia Care Pathway. The audit found: poor compliance with the bench mark set within the Trust; a lack of an up to date dementia care pathway within the Dementia, Delirium, Falls Clinical Guideline on the Trust Intranet; a lack of awareness of the Dementia Care Pathway across the Elderly Care MDT; poor uptake by families and carers with regard to their input within the documentation; documentation when started is not kept in the correct location i.e. at the patient bedside; completion of 'This is Me' document is not identified at handover</p>	<p>As a results of this audit: the Dementia, Delirium, Falls Guideline will be reviewed and updated; the 'This is Me' document will be kept in purple folder at patient's bedside; key stakeholders will be approached to assist with education of all ward staff to raise awareness and increase compliance in line with Trust policy. A re-audit is planned in 6 months</p>
3701 – Re-audit of Guidelines for Last offices for	<p>This re-audit shows an improvement in adherence with the last offices policy,</p>	<p>As a result of this audit, it is evident that further effort needs to be taken to</p>



Adults 2016	however adherence is patchy and is not been followed by all wards all of the time (variance between wards is 21% to 99%).	improve staff awareness of the Last Offices Policy. Outcomes and actions from the audit will be shared with Sisters and Matrons and followed up by the End of Life Care Committee.
3791 - Implementation of Wessex Paediatric Sepsis Screening Tool in Dorset County Hospital May 2016	This audit found that only 57% of patients eligible for sepsis screening during the audit period received this. No children triggered the sepsis 6 bundle so we were unable to measure the number receiving IV antibiotics within the target 1 hour.	As a result of this audit: the Wessex Paediatric Screening tool has been embedded in paediatric admission paperwork; education of nursing and medical staff has taken place to increase awareness of sepsis tool; Paediatrics are investigating the possibility of including the sepsis screening tool in Vitalpac assessment
3738 - Choices for paediatric end of life care Feb 2016	This audit found that the majority (83%) of children who have an advanced care plan were offered choices for end of life care (home, Gully's Place or a hospice) and, where there has been a clear plan, those wishes have been met. However, a sudden deterioration in a child's condition could change that option at the end of life. There have been some child deaths where it would have been beneficial to have had an advanced care plan in place	As a result of this audit further work will be done in identifying children in high risk group's e.g. cardiac conditions with poor prognosis, repeated admissions to hospital for children with a life limiting condition, admission to PICU for children with a life limiting condition.  A re-audit is planned in 1 year.
3759 – Detecting foetal growth restriction Sept 2016	This audit found that only 15% of babies with foetal growth restriction are picked up from the current screening method.	As a result of this audit Maternity will implement the GROW package. This package has been shown at other Trusts to detect 60% of babies with foetal growth restriction
2492 – Safeguarding systems in the Emergency Department March 2016	This initial audit has highlighted shortfalls in compliance with our expected standards of	As a result of this audit training has been put in place to ensure that staff are aware of the necessity of

	<p>safeguarding screening in the ED department. The main areas of poor compliance are documenting parental responsibility and reasons for previous attendances. Not all patients who had more than 3 attendances to ED in the last 12 months were referred for further investigation</p>	<p>complete documentation. The ED computer system has been modified to automatically generate a paediatric cas-card which prompts recording of safeguarding information. A specific audit of documentation of father's name has been implemented.</p>
<p>3684 and 3876 – Documentation of father's names for children who attend ED Sept 2016</p>	<p>Audit 2492 had highlighted good practice in recording the adult accompanying children attending ED but poor compliance with recording the name of the father. The importance of recording the fathers name has been highlighted by serious case reviews. Audit 3684 carried out early in 2016 showed that the fathers name was recorded in only 68% of cases. The ED cas-card was modified to include an area for clearer recording of social history. When re-audited in June 2016 recording the father's name had improved to 80.5% - a number of circumstances have been recognised where it is inappropriate to record the father's name</p>	<p>There is continued training of ED staff at induction in the importance of thorough social history records. A re-audit is planned in 2017</p>
<p>3800 – A re-audit of cognitive assessment in ED March 2016</p>	<p>In 2015 a national audit was carried out around assessment of cognitive impairment in Emergency Departments. Following this audit a key recommendation was the introduction of a CAS card specifically for patients aged over 75 which includes a record of formal assessment of cognitive function using AMT-10. This audit found that the AMT-10 assessment was completed for only 19% of patients. This</p>	<p>As a result of this audit a simplified AMT-4 assessment will be introduced. A re-audit is planned in 6 months to ensure that this has improved the number of elderly ED patients receiving an assessment of cognitive function</p>

	has been attributed to the amount of time required to carry out AMT-10 in such a busy clinical environment	
3883 – A re-audit of oxygen prescription July 2016	In September 2014, this Trust changed the method of prescribing oxygen from a paper based chart to electronic prescribing on JAC. An audit carried out in Feb 2015 identified that only 27% of patients were receiving appropriate prescription of oxygen following this change. An action plan was implemented, the most significant change being the introduction of a 'medical bundle' on JAC. At re-audit in Dec 2015 prescription rates for oxygen have risen 78%.	Continued efforts are being made to improve oxygen prescription on JAC further, including education of junior doctors
3743 - Emergency Readmission Audit Oct 2016	This audit, carried out over a 1 month period, reviewed patients readmitted at DCH. An audit team of primary care, acute care, community care, commissioners and the county council participated. 26 readmissions were found to have been avoidable and the main causes of avoidable readmission included: <ul style="list-style-type: none"> <li>• Patient expectations/ understanding of their disease processes and recovery.</li> <li>• Communication between healthcare and patient, primary and secondary care etc.,</li> <li>• Lack of palliative care/ end of life at home.</li> <li>• Condition not managed effectively on initial admission.</li> </ul>	As a result of this audit a comprehensive action plan is in place to involve patients and families in the discharge process and improve communication between acute, primary and social care teams.
3553 - Audit of intraoperative cataract surgery complications at Dorset County Hospital from 1st June 2014 to 1st June 2015 submitted June 2016	This audit provides reassurance that rates of intraoperative complications from cataract surgery are much better than national rates. The audit found only 4	No changes are required in technique

	cases of vitreous loss and capsular tear out of 1214 procedures i.e. 0.32% (National rates are 1.92%)	
3280 - A re-audit of carcinoembryonic antigen (CEA) measurement in patients diagnosed with colorectal cancer. May 2016	NICE Guidelines published in 2014 recommended that regular CEA tests are carried out at least every 6 months in the first 3 years of follow up of patients who have had surgery for colorectal cancer. A preoperative CEA blood test is therefore needed as a baseline measurement. This audit found that 76% of patients had a pre-operative CEA, those that didn't were predominantly admitted as an emergency admission for surgery on CEPOD.	As a result of this audit all FY1s are encouraged to add CEA to the bloods taken for those patients who are admitted as an emergency with suspected colorectal cancer. The Cancer Nurse Specialist will also check this. In addition, all patients will have CEA measurements following curative resection as part of their follow up for 3-5 years
3369 - Assessment of Resource Utilisation in Breast Surgery Jan 2017	This service review found that following introduction of day surgery and other improvements to service (i.e. better pre-op planning, patient education and pre-assessment, higher quality surgery and anaesthesia (regional blocks, avoiding post-op opioids), optimised post-op care and discharge planning) the length of stay for inpatients reduced from 2.4 days in 2012 to 2.0 days in 2014. In addition, the length of stay for day surgery patients reduced from 10 hrs in 2012 to 7.1 hrs in 2014. During this time there was no increase in re-admission rates and overall patient experience was good.	The breast team will continue to make changes to optimise care and reduce length of stay
3671 - Difficult Intubation Guidelines 2015	The aim of this audit was to assess anaesthetist's awareness of the Difficult Airway Society guidelines which were updated in 2015. The audit found an average score of 60% awareness of	As a result of this audit a teaching session was carried out to educate anaesthetists about the new changes. A re-assessment of knowledge is planned

	recommendations i.e. all anaesthetists were aware of more than half of the new guidelines	
3269 - Assessing time to CT scanning for head injuries Dec 2016	This audit found that only 19% of patients who met the NICE head injuries criteria for urgent (< 1 hr) scanning had their scan carried out within that timeframe. The most common point of delay was from booking in to being seen by a doctor	As a result of this audit a triage tool for head injuries has been discussed with the Emergency Department. Junior doctors will be educated about head injury management at each induction. The use of the head injury proforma will be encouraged
3809 - The Efficiency of Discharge Summary Completion After A Patient Dies 2015/16	This snapshot audit of patients who died at DCH in February found that of the 64 people who died, only 13 (20%) discharge summaries were completed within the expected 24hours. By May 2016 17% were still not complete. The audit also revealed issues of accuracy, three of the completed discharge summaries failed to mention the patient had died. The average time for completion (of those summaries actually done) was 25 days.	As a result of this audit posters have been displayed in the bereavement office where Death Certificates are completed to remind doctors to complete discharge summaries at the same time. A teaching session for new junior doctors with the bereavement team to ensure this becomes standard practice for the new doctors joining the hospital each year.
3843 – Pressure ulcer audit May 2016	This survey was carried out to assess the level of knowledge of nursing staff in the identification and grading of pressure ulcers. The survey found that knowledge amongst trained staff is greater than support workers. There is still a requirement to provide education regarding the key differences between pressure ulcer grades and the differentiation between moisture lesions and pressure ulcers.	As a result of this audit our wound assessment forms are being updated. In addition a training need has been identified and our tissue viability nurses will work with the education centre and ward sisters to meet this training need

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2016 -2017 that were recruited during that period to participate in research approved by a research ethics committee was 1216 (the highest number achieved to date).

A proportion of the Trust's income in 2016- 2017 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation Payment framework.

In 2016 – 2017 2% of our clinical income depended on achieving these goals. This equated to £3,107,352, of which we secured £3,067,808 (98.7%).

The Trust is required to register with the Care Quality Commission (CQC) and its current status is registered in full without conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2016- 2017.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. (The Trust did participate in a system wide Safeguarding Children review for the Local Authority).

The Trust submitted records during 2016 -2017 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

	2013/14	2014/15	2015/16	2016/17	National Average
<b>Admitted Patient Care</b>	99.9%	99.9%	99.9%	99.9%	99.3%
<b>Outpatient Care</b>	100%	99.9%	100%	100%	99.5%
<b>Accident and Emergency Care</b>	99.3%	99.3%	99.2%	99.2%	96.7%

The percentage of records which included the General Medical Practice Code was:

	2013/14	2014/15	2015/16	2016/17	National Average
<b>Admitted Patient Care</b>	100%	100%	99.9%	99.9%	99.9%
<b>Outpatient Care</b>	100%	100%	99.9%	100%	99.8%
<b>Accident and Emergency Care</b>	100%	100%	99.5%	99.7%	99.0%

The Trust Information Governance Assessment Report overall score for 2016 – 2017 was 87% and was graded Satisfactory (Green).

The Trust was not subject to the Payment by Results clinical coding audit during 2016 – 2017.







## Reporting Against Core Indicators

### Mandatory Statement 12: Mortality

The Summary Hospital-level Mortality Indicator (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 there.

It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.

A lower score indicates better performance. In addition to individual scores, trusts are categorised into one of three bandings: 1 (SHMI higher than expected); 2 (SHMI as expected); 3 (SHMI lower than expected).

Summary Hospital-level Mortality Indicator	2012/13	2013/14	2014/15	2015/16	2016/17*	Trend
<b>Banding</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>N/A</b>	
<b>Value</b>	<b>1.07</b>	<b>1.11</b>	<b>1.10</b>	<b>1.16</b>	<b>N/A</b>	
<b>% of patient deaths with palliative care coded at either diagnosis or speciality level</b>	<b>12.0%</b>	<b>13.5%</b>	<b>15.7%</b>	<b>24.9%</b>	<b>N/A</b>	
<i>National Average</i>	<i>19.9%</i>	<i>23.6%</i>	<i>25.7%</i>	<i>28.5%</i>	<i>N/A</i>	
<i>Lowest</i>	<i>0.1%</i>	<i>0.0%</i>	<i>0.0%</i>	<i>0.6%</i>	<i>N/A</i>	
<i>Highest</i>	<i>44.0%</i>	<i>48.5%</i>	<i>50.9%</i>	<i>54.6%</i>	<i>N/A</i>	









The Trust has seen an increase in SHMI and a decrease in banding. This is being reviewed through the Hospital Mortality Committee, and the new guidance published by NHSI is being implemented.

### Mandatory Statement 18: PROMs

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.





## DCHFT Annual Report and Accounts 2016/17

Patient Reported Outcome Measures (PROMs)	2012/13	2013/14	2014/15	2015/16	2016/17*	Trend
<b>Groin Hernia</b>						
<b>Dorset County Hospital</b>	<b>0.076</b>	<b>0.076</b>	<b>0.066</b>	<b>N/A</b>	<b>N/A</b>	
National Average	0.085	0.085	0.084	0.088	0.089	
Lowest						
Highest						
<b>Hip replacement</b>						
<b>Dorset County Hospital</b>	<b>0.461</b>	<b>0.445</b>	<b>0.466</b>	<b>0.468</b>	<b>0.458</b>	
National average	0.438	0.436	0.437	0.438	0.449	
Lowest						
Highest						
<b>Knee replacement</b>						
<b>Dorset County Hospital</b>	<b>0.304</b>	<b>0.297</b>	<b>0.305</b>	<b>0.32</b>	<b>0.337</b>	
National average	0.318	0.323	0.315	0.341	0.313	
Lowest						
Highest						
<b>Varicose Vein</b>						
<b>Dorset County Hospital</b>	<b>N/A</b>	<b>N/A</b>	<b>0.099</b>	<b>0.095</b>	<b>N/A</b>	
National average	N/A	N/A	0.095	0.126	0.099	
Lowest						
Highest						
<b>*2016/17 April - September data only</b>						
Source						
<a href="http://content.digital.nhs.uk/proms">http://content.digital.nhs.uk/proms</a>						

A higher number demonstrates that patients have experienced a greater improvement in their health.

### Mandatory Statement 19: Readmissions

The table below shows the percentage of emergency readmissions to the Trust within 28 days of a patient being discharged.

Readmissions within 28 days	2012/13	2013/14	2014/15	2015/16	2016/17	Trend
<b>Aged 0 to 15 years</b>						
Total Spells	5,147	4,749	4,676	4,948	4,975	
Of which, readmitted as an emergency within 28 days	456	393	442	471	488	
<b>Dorset County Hospital</b>	<b>8.9%</b>	<b>8.3%</b>	<b>9.5%</b>	<b>9.5%</b>	<b>9.8%</b>	
National average	N/A	N/A	N/A	N/A	N/A	
Lowest	N/A	N/A	N/A	N/A	N/A	
Highest	N/A	N/A	N/A	N/A	N/A	
<b>Aged 16 years and over</b>						
Total Spells	16,832	16,103	17,567	18,263	18,837	
Of which, readmitted as an emergency within 28 days	1,741	1,695	1,994	2,222	2,295	
<b>Dorset County Hospital</b>	<b>10.3%</b>	<b>10.5%</b>	<b>11.4%</b>	<b>12.2%</b>	<b>12.2%</b>	
National average	N/A	N/A	N/A	N/A	N/A	
Lowest	N/A	N/A	N/A	N/A	N/A	
Highest	N/A	N/A	N/A	N/A	N/A	

Source Internal DCH report which follows the guidance as stated on p22 of:





[https://imprcvement.nhs.uk/uploads/documents/Detailed\\_req\\_for\\_assurancefor\\_qual\\_repts\\_16-17.pdf](https://imprcvement.nhs.uk/uploads/documents/Detailed_req_for_assurancefor_qual_repts_16-17.pdf)

NHS Digital has not published the recommended source reports since December 2013



## Mandatory Statement 20: Responsive

The indicator is a composite, calculated as the average of five survey questions taken from the annual national inpatient survey.

Responsiveness to the personal needs of patients	2012/13	2013/14	2014/15	2015/16	2016/17	Trend
Dorset County Hospital	66.9	69.9	71.1	69.6	N/A	
National average	68.1	68.7	68.9	69.6	N/A	
Lowest	57.4	54.4	59.1	58.9	N/A	
Highest	84.4	84.2	86.1	86.2	N/A	
Source						
<a href="https://indicators.hscic.gov.uk/webview/">https://indicators.hscic.gov.uk/webview/</a>						

The overall score can range from 0 to 100, a higher score indicating better performance. If all patients were to report all aspects of their care as 'very good' this would equate to an overall score of 80. A score of approximately 60 would indicate 'good' patient experience.

## Mandatory Statement 21: Staff Friends and Family Test

The Trust gauges staff responses in each quarter as to whether they would recommend the Trust to family or friends as a place to receive treatment. In quarters 1, 2 and 4 this information is gathered via the staff friends and family test (Staff FFT); in quarter 3 this test forms part of the national staff survey.

Staff survey feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	2014	2015	2016
Dorset County Hospital	70%	74%	<b>76%</b>
National Average (median)	65%	69%	<b>70%</b>




Staff FFT feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	Quarter 1	Quarter 2	Quarter 4
Dorset County Hospital	82%	82%	77%
National Average (mean)	80%	80%	
Highest	100%	100%	
Lowest	50%	44%	

The Trust has taken a number of actions to improve staff satisfaction and in turn the quality of its services. Actions taken in 2016 in response to staff feedback include the introduction of a Trust-wide leadership development programme, further investment in training and development for staff and a review of Trust values and behaviours. Further work continues this year to continue to improve based on staff feedback, in line with the Trust's Staff Engagement Action Plan.

### Mandatory Statement 23: VTE

Venous thromboembolism (VTE) is an international patient safety issue and a clinical priority for the NHS in England.

VTE is a collective term for deep vein thrombosis (DVT) – a blood clot that forms in the veins of the leg; and pulmonary embolism (PE) – a blood clot in the lungs. It affects approximately 1 in every 1000 of the UK population and is a significant cause of mortality, long term disability and chronic ill-health problems.

Rate of admitted patients assessed for VTE	2012/13	2013/14	2014/15	2015/16	2016/17*	Trend
Admissions	24,026	87,426	91,462	96,063	96,797	
Of which, VTE risk assessed	22,077	85,211	87,371	92,847	92,813	
% VTE risk assessed	91.9%	97.5%	95.5%	96.7%	95.9%	
NHS Standard	92.0%	95.0%	95.0%	95.0%	95.0%	
National Average	94.0%	95.8%	96.1%	95.8%	95.6%	
Lowest	80.2%	66.7%	88.6%	76.9%	78.7%	
Highest	100.0%	100.0%	100.0%	100.0%	100.0%	

2016/17 national average/lowest/highest up to December 2016.

Source: <https://www.england.nhs.uk/statistics/statistical-work-areas/vte/>

The Trust has consistently achieved above both the NHS Standard and the National Average in this core indicator.

### Mandatory Statement 24: C-Difficile

**Clostridium difficile**, also known as **C. difficile** or **C. diff**, is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, but can spread easily to others.

C-difficile rates per 100,000 bed-days	2012/13	2013/14	2014/15	2015/16	2016/17	Trend
Bed-days	101,156	102,674	98,654	105,353	N/A	
C-difficile cases	22	27	15	24	N/A	
<b>C-difficile rate</b>	<b>21.7</b>	<b>26.3</b>	<b>15.2</b>	<b>22.8</b>	N/A	
<i>National Average</i>	<i>17.4</i>	<i>14.7</i>	<i>15.0</i>	<i>14.9</i>	<i>N/A</i>	
<i>Lowest</i>	<i>0.0</i>	<i>0.0</i>	<i>0.0</i>	<i>0.0</i>	<i>N/A</i>	
<i>Highest</i>	<i>31.2</i>	<i>37.1</i>	<i>62.6</i>	<i>66.0</i>	<i>N/A</i>	

Source

<https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data%20>

Although the Trust did experience an increase in C-difficile rates (as consistent with the national picture), significant reductions have been made in 2016/17. Data is yet to be nationally published, but internal data identifies 7 cases acquired post 72 hours admission to hospital in 2016/17.

## Mandatory Statement 25: Incidents

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

Patient safety incidents reported	2012/13	2013/14	2014/15	2015/16	2016/17	Trend
Number of patient safety incidents reported to NRLS	2,945	1,736	2,116	4,609	N/A	
Admissions	51,184	50,530	98,666	105,413	N/A	
<b>Incident rate per 100 admissions</b>	<b>5.8</b>	<b>3.4</b>	<b>2.1</b>	<b>4.4</b>	<b>N/A</b>	
<i>National Average</i>	<i>7.1</i>	<i>7.7</i>	<i>3.6</i>	<i>3.9</i>	<i>N/A</i>	
<i>Lowest</i>	<i>2.5</i>	<i>3.0</i>	<i>1.7</i>	<i>1.6</i>	<i>N/A</i>	
<i>Highest</i>	<i>27.8</i>	<i>30.4</i>	<i>10.2</i>	<i>13.0</i>	<i>N/A</i>	
Incidents resulting in severe harm or death	25	3	19	25	N/A	
<b>Percentage of incidents resulting in severe harm or death</b>	<b>0.85%</b>	<b>0.17%</b>	<b>0.90%</b>	<b>0.54%</b>	<b>N/A</b>	
<i>National Average</i>	<i>0.65%</i>	<i>0.55%</i>	<i>0.49%</i>	<i>0.41%</i>	<i>N/A</i>	
<i>Lowest</i>	<i>0.00%</i>	<i>0.00%</i>	<i>0.00%</i>	<i>0.00%</i>	<i>N/A</i>	
<i>Highest</i>	<i>3.34%</i>	<i>3.90%</i>	<i>4.18%</i>	<i>1.74%</i>	<i>N/A</i>	

Source

<https://indicators.hscic.gov.uk/webview/>

The Trust has seen an increase in the number of safety incidents reported, correlating with an increase in admissions. The trust actively encourages staff to report incidents and 'near-miss' episodes to ensure that key learning points are shared throughout the organisation.

## Part 3 – Other Information

### Care Quality Commission (CQC) Rating

The Trust was rated 'Requires Improvement' by the CQC following inspection in March 2016. The areas identified as both 'Must – do's' and 'Should – do's' were collated into a Trust wide improvement plan, with many of the actions now completed. Evidence has been submitted to ensure that the CQC are satisfied that we have now addressed their recommendation.

The ratings grid below, as published by the CQC on its website, shows the ratings given to the eight core services and five domains at the time of their inspection:

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Urgent &amp; emergency services</b>	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
<b>Medical care</b>	Requires Improvement	Good	Good	Good	Good	Good
<b>Surgery</b>	Requires Improvement	Good	Good	Good	Good	Good
<b>Critical care</b>	Good	Good	Good	Requires Improvement	Good	Good
<b>Maternity &amp; gynaecology</b>	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
<b>Children &amp; young people</b>	Good	Good	Good	Good	Good	Good
<b>End of life care</b>	Requires Improvement	Requires Improvement	Good	Good	Inadequate	Requires Improvement
<b>Outpatients &amp; diagnostic imaging</b>	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
<b>Overall</b>	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

## Patient Safety – Zero tolerance to Hospital Acquired Pressure Ulcers

Goal for 2016-2017:

We will reduce the number of pressure ulcers developed in hospital by 10% compared to 2015-2016

### What is a pressure ulcer?

Pressure ulcers, previously known as bed sores, are types of injuries caused when pressure is applied to the skin over a period of time, resulting in damage to both the skin and the underlying tissues. The presentation can vary in both size and severity from small areas of blistered or discoloured skin to large open wounds. They are nationally graded in terms of severity from Grade I (low damage) to Grade IV (severe damage).

Pressure ulcers cause patients acute discomfort, can prolong their stay in hospital and contribute to other risk factors such as infection. The development of a pressure ulcer in any setting provides the patient with a lifelong risk as the tissue from any healed ulcer will only ever achieve approximately 70% strength of previously undamaged tissue. Therefore it is imperative that no patients are placed at this risk from the care we provide in our trust.

### How did we perform?

During 2016-2017, the Trust has employed various strategies to help us to achieve this goal. These include:

- **The role of the Tissue Viability Nurse (TVN)** - The Tissue Viability team has been hosting a series of study days during 2016-2017 with attendees invited from Nursing and Residential homes across Dorset. The events are supported by a combination of industry and in house speakers. The clinical commissioning group have requested that the Acute Trusts provide education as part of the Pan Dorset Pressure Ulcer Prevention Strategy.

A new 'Skin Tear' protocol has been uploaded to the Trust Intranet, with planned education for all wards from April 2017 onwards.

- **Prevention strategy** - Following a successful trial of hybrid pressure relieving mattresses at the end of 2016, phase one of the planned roll out of hybrid mattresses to all of the wards is underway. Anecdotal evidence from patients via the nursing staff suggests patients find the hybrid mattress very comfortable, with no noise to disturb sleep (this was a complaint with the previous air mattresses).
- **Treatments** - The Tissue Viability team regularly engage with Industry, Procurement and Medical Devices to examine/review the latest products utilised in the prevention and treatment of pressure damage.

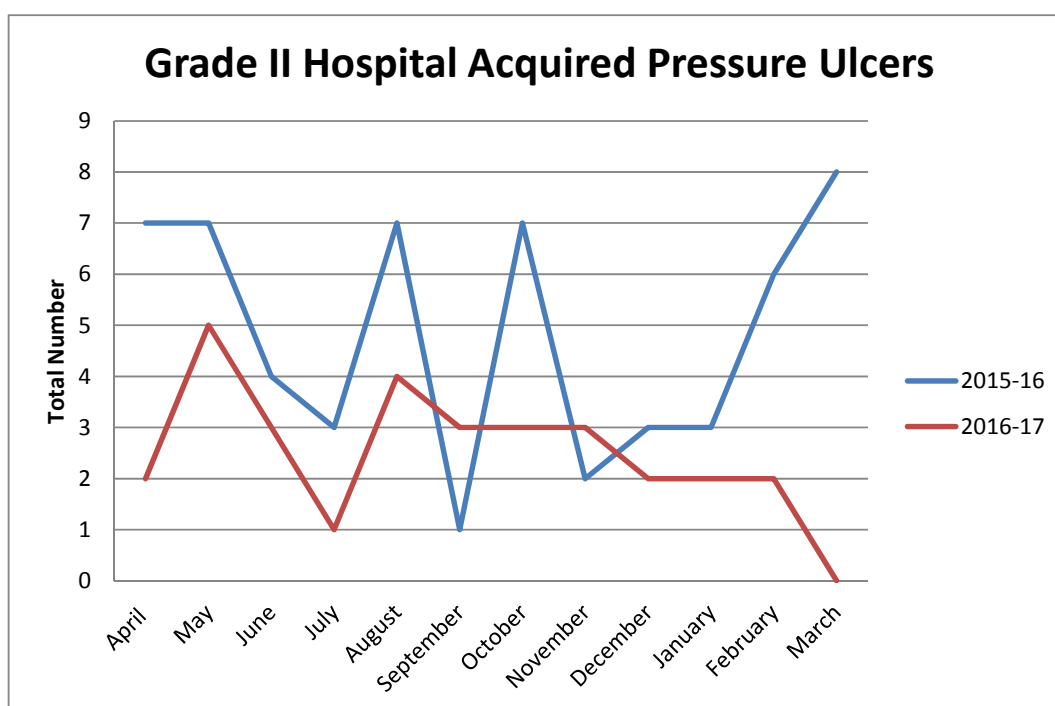
As part of the Pan Dorset Wound Formulary group, a non -formulary anti-microbial dressing is being trialled and evaluated at the Trust. Feedback will be provided to the group and a decision made whether to include the dressing in the revised formulary document.

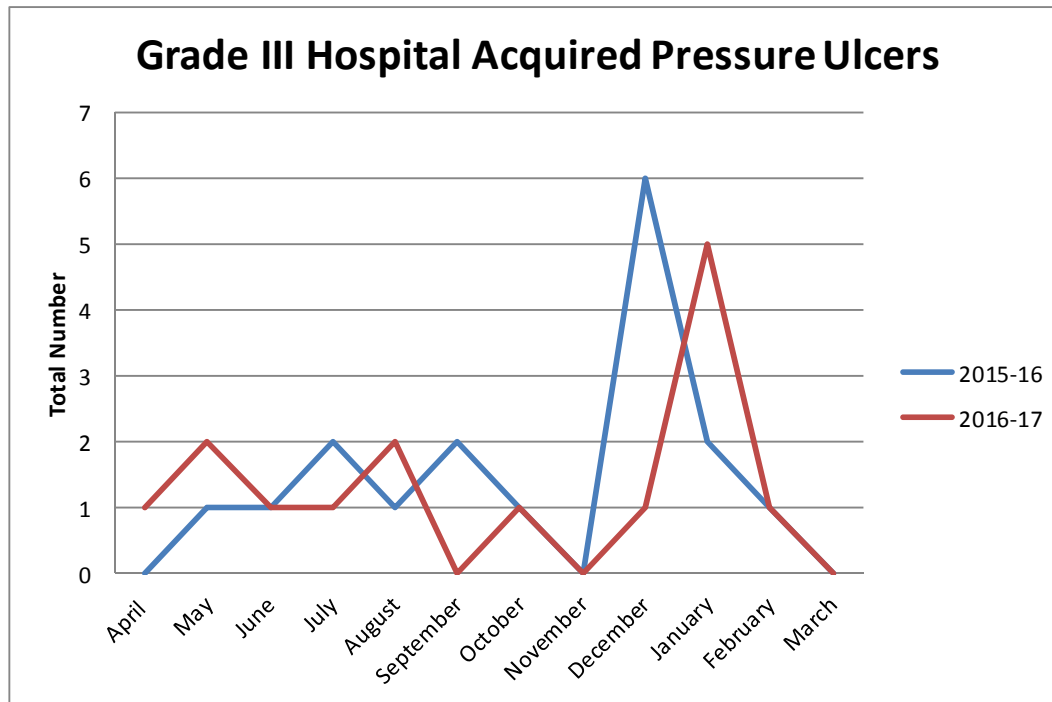
- **Pressure ulcer data** - Pressure Ulcer review meetings are held monthly with the Deputy Director of Nursing and Quality, the Risk department and Tissue Viability to ensure that any recurrent themes or trends are identified and that learning is shared.

Further knowledge audits of pressure ulcer prevention/treatment and reporting amongst nursing staff are planned for 2017.

## Total numbers:

	2015-2016	2016-2017	Percentage Reduction
<b>Grade II Pressure Ulcers</b>	58	17	<b>71%</b>
<b>Grade III Pressure Ulcers</b>	17	15	<b>13%</b>
<b>Overall Pressure Ulcers</b>	75	32	<b>57%</b>





In summary, the Trust has seen a consistent decrease in the number of both Grade II and Grade III pressure ulcers. The graph above demonstrates an increased occurrence of Grade III pressure ulcers observed annually in the November- February period which is consistent with an increase in both activity and acuity of our patients. The Trust will be working on the themes associated with this for 2017/18 to identify any factors that may be contributing towards this and will monitor this priority now through the internal Quality Committee.

## Patient Safety – Improved Mortality Surveillance and Reducing Variation

Goal for 2016-2017:

We will ensure that we have robust mechanisms in place for the reviewing of our mortality data and associated coding. We will establish a mortality surveillance group and agree a standardised approach to mortality and morbidity meetings carried out by each speciality.

### What is mortality surveillance?

Mortality surveillance is the ongoing systematic monitoring and analysis of mortality data, and the sharing of information that leads to actions being taken to address either data quality issues (the way things are recorded and coded) or health concerns/care delivery.

### How did we perform?

The Hospital Mortality Committee (HMC) was set up in April 2016, as part of a national drive to make sure every death in hospital is both reviewed and that lessons are learned.

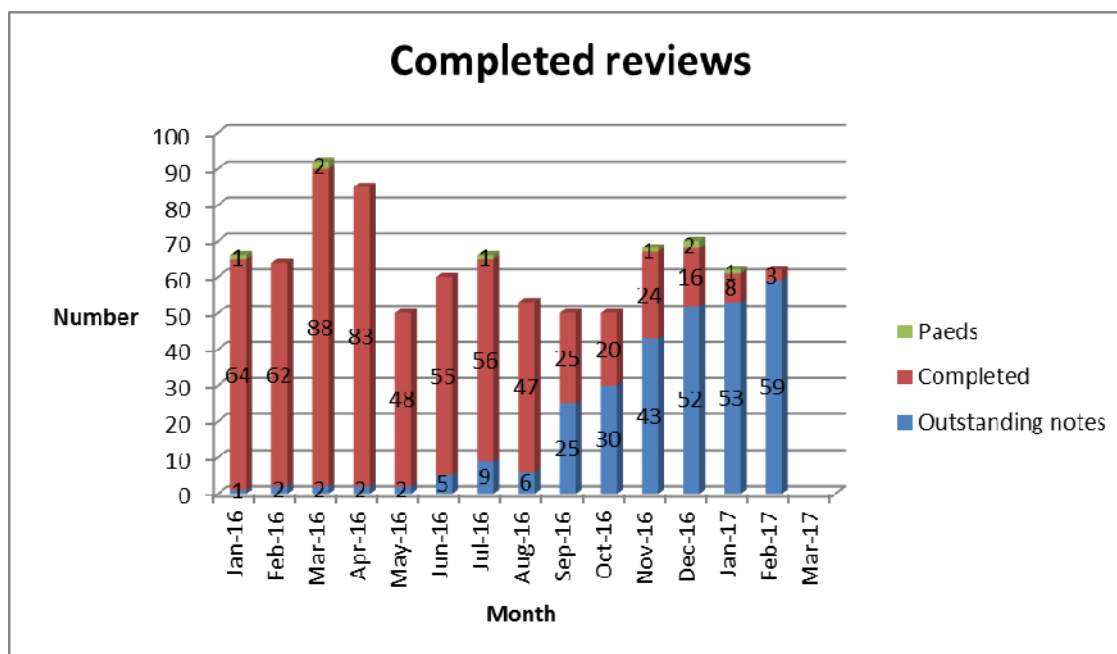
The Committee membership is drawn from the multidisciplinary team at the Trust, with Consultant representation from medical and surgical specialties, anaesthetics, senior nurse, pharmacy, interventional radiology, junior doctor, governance and a member of the Clinical Commissioning Group (CCG).

Notes reviews took place using the agreed proforma used by the HMC, to include:

- Source of admission (own home, NH/RH, community hospital, other acute NHS Trust);
- A brief case summary (presentation, co-morbidities, working diagnosis, significant clinical interventions);
- Time from admission to consultant review/ ongoing consultant review;
- Treatment of sepsis, if applicable
- Areas of good practice e.g. evidence of end of life care
- Involvement of the patient/next of kin in treatment plan
- Areas for improvement

The Trust also included reviews of any deaths of patients who had been discharged within 30 days to ensure that any underlying themes or trends could be examined.

614/902 cases have been reviewed to date, which represents 68.7% of the total number of deaths during the time frame. This includes 8 paediatric cases which have been, or will be reviewed separately through the Child death Review meetings.





However, in March 2017 the National Quality Board published the 'National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care' for implementation in all trusts in April 2017.

## National Guidance on Learning from Deaths

A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

**National Quality Board**



First edition March 2017

This comprehensive document provides details of how all organisations must select cases for review, alongside a framework for the investigation process required. All trusts will be required to publish public data according to this guidance.

The Trust is currently working through this new guidance to ensure that the review of deaths is a robust process which complies with the standards expected by the national guidance.

For this reason and due to the increasing backlog of notes to be reviewed, a new process for triaging and reviewing notes was agreed at the Hospital Mortality Committee in April 2017 and this remains a quality priority for the trust in the forthcoming year.

### **What is the Summary Hospital-level Mortality Indicator**

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and 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 there.

### **How did we perform?**

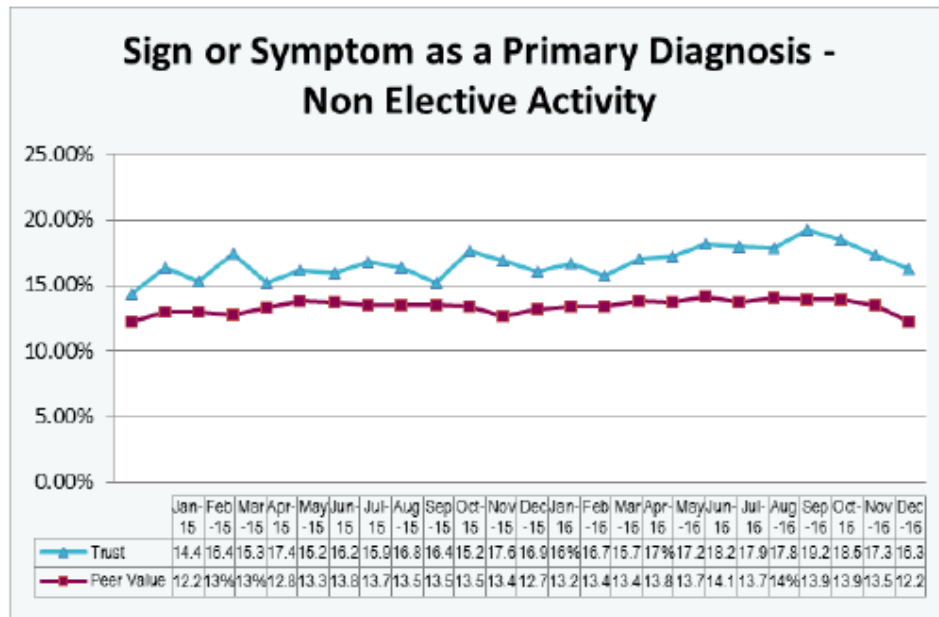
We constantly monitor our performance against the National Standards and our peers and we have noticed that over the last two years (July 2014 – Jun 2016), our performance on this

particular indicator (SHMI) has been consistently higher than the national average. A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance<sup>1</sup>. Instead, it should be viewed as a 'smoke alarm' which requires further investigation by the trust. Similarly, a 'lower than expected' SHMI should not immediately be interpreted as indicating good performance. In that respect, the crude mortality rate for DCH remains stable which indicates that the quality of care has not changed. Further analysis of the data indicates that there are reporting issues that could have contributed to the recent increase of our SHMI score.

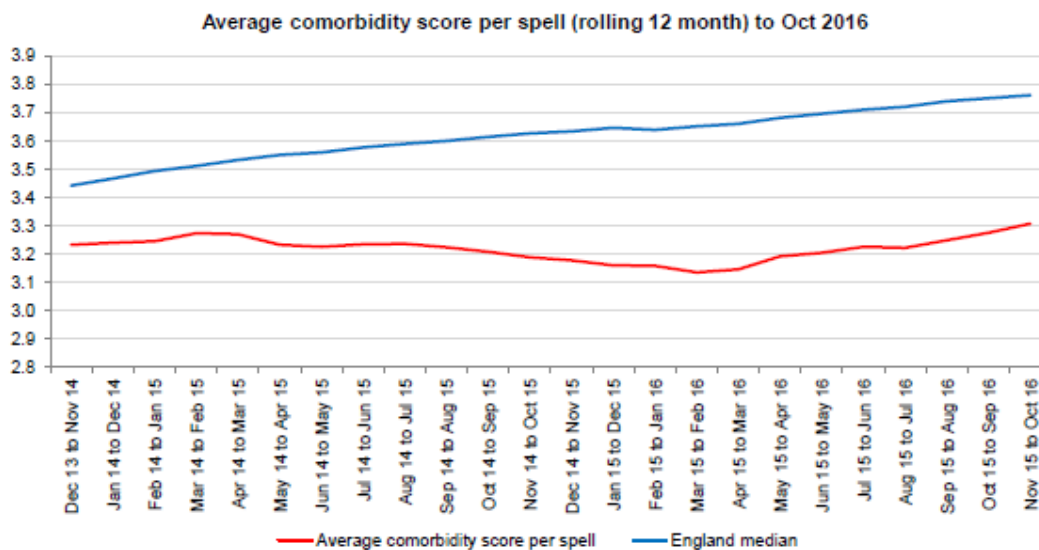
Data	Oct 2012 - Sep 2013	Jan 2013 - Dec 2013	Apr 2013 - Mar 2014	Jul 2013 - Jun 2014	Oct 2013 - Sep 2014	Jan 2014 - Dec 2014	Apr 2014 - Mar 2015	Jul 2014 - Jun 2015	Oct 2014 - Sep 2015	Jan 2015 - Dec 2015	Apr 2015 - Mar 2016	Jul 2015 - Jun 2016
SHMI	1.08	1.12	1.11	1.10	1.12	1.08	1.10	1.12	1.13	1.15	1.16	1.15
Crude Mortality Rate	3.6%	3.8%	3.7%	3.7%	3.8%	3.7%	3.9%	3.9%	3.8%	3.7%	3.7%	3.7%
England Crude Mortality Rate	3.3%	3.2%	3.1%	3.1%	3.1%	3.2%	3.3%	3.3%	3.3%	3.3%	3.2%	3.2%
Deaths in excess of expected	81	118	106	92	120	80	105	129	133	150	161	149
Lower Limit	0.89	0.88	0.89	0.89	0.89	0.90	0.90	0.90	0.90	0.89	0.89	0.89
Upper Limit	1.13	1.13	1.13	1.13	1.12	1.12	1.11	1.12	1.12	1.12	1.12	1.13

The Summary Hospital-level Mortality Indicator (SHMI) score depends on the accurate and timely recording of patient data including a definitive diagnosis and an accurate list of their comorbidities. The information captured by the clinicians should be translated by the Clinical Coding team to diagnostic codes which allows a relevant risk to be associated with the diagnosis. The analysis of our data has shown that a rather high number of non-elective patients do not have a definitive diagnosis during the first two episodes of their treatment. These patients are assigned a "Sign or Symptom Code" rather than a diagnosis code. The risk score associated with a "Sign or Symptom Code" is extremely low which causes the mortality indicator (SHMI) to rise. In the graph below, we can clearly see that the number of "Sign or Symptom Codes" used in DCH is considerably higher than that of our peers. Our target is to decrease the use of "Sign or Symptom Codes" for all patients within the next months.

<sup>1</sup> SHMI: guidance for trusts, NHS Digital, 2017



Similarly, we have noticed a rather low number of comorbidities recorded for DCH patients compared to the national average. Given the case mix of our patients, we would expect that the average number of comorbidities per spell to be closer or even higher than the national average (see graph below).



An improvement action plan to reduce SHMI has been agreed and approved by the Quality Committee. A dashboard with all the indicators that can impact SHMI has been produced and monitored on a monthly basis.

## **Patient Safety – Reducing the incidence of Severe Sepsis and managing patients effectively when admitted with this condition**

Goal for 2016-2017:

We will increase our sepsis screening rates up to 90% and administer antibiotics within 1 hour for those patients who require them.

### **What is Sepsis?**

Sepsis is a life-threatening condition in which the body is fighting a severe infection that has spread via the bloodstream and begins to injure its own tissues and organs. If a patient becomes "septic," they will likely have low blood pressure leading to poor circulation and lack of blood perfusion of vital tissues and organs.

Sepsis kills 44,000 people annually in the United Kingdom. International estimates of incidence vary, but consensus points to approximately 300 cases per 100,000 population per annum. There are approximately 210,000 people in the Trust's catchment area resulting in an expected incidence of more than 600 cases of severe sepsis and septic shock annually.

The early identification and treatment of sepsis has been demonstrated to reduce mortality from sepsis by 50%. Recording of Sepsis is acknowledged as a complex issue nationally and efforts are being made to review how sepsis is recorded.

### **How did we perform?**

The Trust has been committed to a series of awareness raising events to support staff in the identification and screening of Sepsis, such as 'Sepsis Week' in September 2016 and has also participated in the Academic Health Science Network safety collaborative.

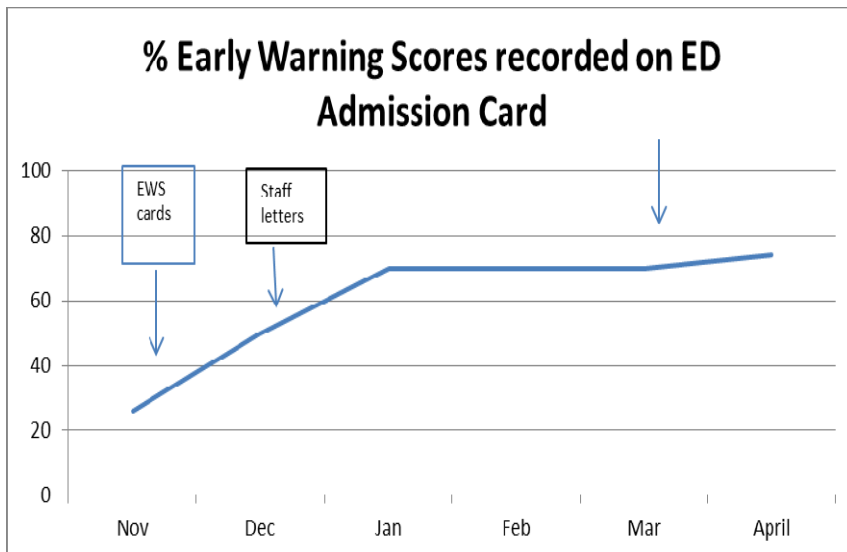
One of our wards developed a poster to support both staff in the hospital and our GP practices to recognise the signs/symptoms of Sepsis and act appropriately, and this is now due to be distributed to our colleagues in Primary Care.



In order to gain the momentum required and to embed the culture of identifying Sepsis in the early stages, one of the targeted areas the trust has been focused on is the Emergency Department.

The initial stages of sepsis screening require an assessment of the patients Early Warning Score (EWS). This is a score that indicates if a patient has either physiological observations or signs that could indicate Sepsis and prompt the clinician to take further action.

Audits of the recording of this score on admission to the Emergency Department have demonstrated that there has been an improvement in this being completed.



The Trust recognises that there is further progress required in this area as it did not achieve its target reduction. The work plan of the Sepsis Committee has been refreshed and so this remains a quality priority for the trust in the forthcoming year.

### Clinical Effectiveness – Implementation of improved discharge processes

Goal for 2016-2017:

We will reduce the amount of patients who are waiting to be discharged from hospital by having less than 3.5% of our beds occupied with delayed transfers of care.

#### What are discharge processes?

Discharge processes are used to decide what a patient needs for a smooth transition from one level of care to another. The actual process of discharge planning can be completed by a social worker, doctor, nurse or therapist. Ideally, and especially for the most complicated medical conditions, discharge planning is done with a team approach.

In general, the basics of a discharge plan are:

- Evaluation** of the patient by qualified personnel

- Discussion** with the patient or family

- Planning** for homecoming or transfer to another care facility

- Determining** if caregiver training or other support is needed

- Referrals** to home care agency and/or appropriate support organisations in the community

- Arranging** for follow-up appointments or tests

The discussion needs to include the physical condition of the patient both before and after hospitalisation; details of the types of care that will be needed; and whether discharge will be to another care location or home. It also should include information on whether the patient's condition is likely to improve; what activities he or she might need help with; information on medications and diet; what extra equipment might be needed, such as a wheelchair, commode, or oxygen; who will handle meal preparation, transportation and chores; and possibly referral to home care services.

#### How did we perform?

Delayed Transfers of Care have consistently been above the national target of 3.5% during 2016/17, but performance has improved in comparison to 2015/16 – a 0.3% reduction in delayed transfers of care and a reduction in the number of bed days lost through delayed transfers of care (96 bed days), which are shown in the table below.

Month	Number of Delayed Discharges	Number of Occupied Beds	% Delayed Transfers of Care (DCH Methodology)	Number of Days Occupied by Delayed Transfers	Days in Month	% Delayed Transfers of Care (NHSE Methodology)
2014/15	702	13376	5.2%	3647	365	3.5%
2015/16	1083	14200	7.6%	5248	366	5.0%
2016/17	1085	14928	7.3%	5152	365	5.0%

Delayed Transfers of Care remain a significant problem, the continuing issue of timely access to care packages, care home placements and community hospital beds remains an issue for patients at the Trust, but is widely acknowledged as a national issue.

In response the Trust, with partners, have undertaken a series of improvements to help support improvement to the delayed transfer of care agenda:

### 1. Discharge Project

- Planning and implementation of the SAFER Patient Flow bundle across the hospital (ongoing throughout 2017/2018).
- Discharge pathway and process training to clinicians across the Trust. This training has been attended by community services (Dorset Healthcare NHSFT) clinicians also. The training encompasses soft skills training to support difficult conversations, availability and access to services for support, and troubleshooting complex discharges
- Working with IT system providers (VitalPac, Digital Patient Record) to establish improved tracking and reporting systems for discharge planning (linked to Estimated Discharge Dates). This will be ongoing throughout 2017/2018.

### 2. Queen Charlotte Nursing Home Project

A pilot at Queen Charlotte Nursing Home commenced on 1<sup>st</sup> February 2017 for step-down assessment for long term care. This is being delivered in partnership with Dorset County Council, Weymouth GPs and Kingsley Healthcare. The project has already seen a reduction in the delayed discharge list (for nursing care), which is the highest category of delay at the Trust. The pilot will be evaluated mid-end May 2017.

### 3. CHS (Care Home Select Ltd) Implementation

CHS provide personalised support for self-funding patients and family, supporting them to quickly focus on the most relevant care providers for onward support to facilitate a rapid and safe discharge from hospital. Advisers can transport families to view homes and enable a choice to be made without unnecessary delay. CHS advisers work flexibly, including evenings and weekends. CHS are currently undertaking a 6 month pilot (due



to end in June 2017) across supporting 3 acute hospitals and community hospitals in Dorset.

#### **4. The British Red Cross**

The British Red Cross have implemented their 'Support at Home Service' at the Trust, from November 2016, for a period of 18 months initially.

The aim of the service is to patients provide short-term support to smooth the process of settling back into a normal routine at home and enable people to regain their confidence and independence.

The support offered by volunteers is taken on a case by case basis but can include:

- helping regain confidence and independence
- doing shopping or taking them shopping
- collecting prescriptions
- providing welfare checks
- transporting to and from medical appointments
- providing access to medical equipment
- alleviate social isolation

#### **5. Care Home Engagement**

Local care home and domiciliary care providers have agreed to initiate a project to improve discharge pathways and the patient experience for patients transferring from the Trust to home/care home. There are several areas of improvement that have been identified for organisations to work on jointly, including initiating a single point of contact for providers/homes at the Trust to discuss patient progress, implementing a pathway for patient discharge, creating improved documentation for admission/discharge. Organisations are committed to building relationships and building on this to improve.



## **Clinical Effectiveness – Increase the percentage of Electronic Discharge Summaries (EDS) sent within 24 hours**

Goal for 2016-2017:

We will increase the percentage of EDS sent within 24 hours to 90% and reduce the number of incidents reported where this does not occur.

### **What is an Electronic Discharge Summary (EDS)?**

A discharge summary is an electronic letter written by the doctor (or nurse) caring for the patient in hospital. It contains important information about the hospital visit, including:

- Why the patient came into hospital
- The results of any tests
- The treatment the patient received
- Any changes to medication
- What follow-up is needed

The main aim of the discharge summary is to inform the GP about what happened during the hospital visit. This means that the GP can change prescription(s) according to the advice of the hospital doctors, chase any test results which weren't available whilst the patient was in hospital, and arrange further investigations or referrals as necessary.

Ultimately, a discharge summary helps all staff provide the best possible care.

### **How did we perform?**

A new EDS system, linked to ICE (computer system) has been rolled out across the Trust and the 'old' system is now read only (from the beginning of July).

The incomplete EDS report for the new system is now sent to Managers and Clinicians on a weekly basis (since October) to raise awareness and an escalation process has been agreed.

The total number of EDSs being completed has risen slightly, as has EDSs completed within 24/48 hours. However, we are aware that there is still a lot of work required in this area in order for us to demonstrate the standards expected.

Metric	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD (July onwards)
Percentage of ICE ToCS created compared to number of discharges recorded	97.3 %	97.8 %	98.1 %	97.7 %	97.8 %	98.1 %	98.0 %	98.0 %	94.5 %	97.4 %
Percentage of discharge summaries available for GPs to access within 24 hrs of discharge	69.7 %	69.4 %	67.7 %	72.7 %	75.0 %	70.9 %	73.4 %	74.6 %	75.1 %	72.1 %
Percentage of discharge summaries available for GPs to access within 48 hrs of discharge	72.2 %	71.7 %	70.5 %	75.9 %	78.0 %	73.7 %	77.6 %	78.1 %	78.0 %	75.1 %

There are some issues with the system that have been highlighted and an action plan is being agreed to resolve these. The full action plan will now be monitored through the Trust's Quality Committee.

Further work is required to resolve the outstanding issues and therefore, this remains a quality account priority for the Trust in the forthcoming year.

## Clinical Effectiveness – Improving Availability and Accessibility of Information to Patients

Goal 2016-2017:

We will make changes to policy, procedure, human behaviour and, where applicable, electronic systems which will lead to improved outcomes and experiences for our patients. We will achieve the requirements of the Information Standard.

## What is the Information Standard?

The Information Standard scheme shows NHS England's commitment to improving the quality of health and care information that is available to the public, patients and health and care professionals.

We believe information that is clear, accurate, evidence-based, up-to-date and easy to use allow people, patients and communities to become better informed and more involved in their health and care.

The Information Standard was developed in response to the large amount of health and care information available to the public and patients. Any organisation achieving The Information Standard has undergone a rigorous assessment to check that their information production process generates high quality information.

Members of The Information Standard also receive the right to display the Standard's logo on their information. This acts as a quality mark and helps people easily identify reliable, high quality information.

## How did we perform?

In 2015, the organisation began the journey of implementing the NHS England Information standard. This required a review of all patient available literature to ensure that the following principles applied to the information provided by the Trust:

- **Information Production** – you have a defined and documented process for producing high quality information
- **Evidence Sources** – you only use current, relevant and trustworthy evidence sources
- **User understanding and involvement** – you understand your users and you user-test your information
- **End Product** – you confirm that your finished information product has been developed following your process and is of good quality
- **Feedback** – you manage comments/complaints/incidents appropriately
- **Review** – you review your products and your process on a planned and regular basis

A full analysis of improvements required was undertaken and this work took place throughout 2015-2016.

NHS England visited the Trust in February 2017 to assess the progress of the improvements required and concluded that:

*'I am delighted to inform you that your organisation has been successful in its application to maintain its certification against The Information Standard. I have attached a copy of the final Assessment report.*

*Finally, I would like to take this opportunity, once again, to offer you and your staff congratulations on your achievement. Maintaining certification for the Information Standard takes a lot of hard work and commitment as well as enthusiasm and it is a great accomplishment for all concerned!*

*You will receive a new certificate in the post shortly confirming certification for another 12 months'.*

*NHS England*

### **Patient Experience – Improving services for patients with Learning Disabilities**

Goal 2016-2017:

We will implement a learning disability specialist post within the Trust to help us understand how we can improve the services we provide and to make adjustments to our clinical areas where required.

#### **How can you improve services for patients with a learning disability?**

People with learning disabilities face serious health inequalities that health services have a duty to reduce.

The impact of these inequalities on the health of people with learning disabilities is serious. The research indicates that people with moderate to serious learning disabilities are three times as likely to die early than the general population. They are more likely to experience poor general health as reported by their main carer and to have high levels of unmet physical and mental health needs.

Therefore, it is imperative that the Trust raises awareness of this, seeks the feedback and experiences of this patient group and determines where services can be improved to reduce this inequality.

## How did we perform?

A new role was created in the trust to support the improvement in services for patients with a learning disability. This post was successfully appointed into and the post holder commenced in the Trust August 2016 and works in conjunction with the Adult Safeguarding Lead. This quality priority is supported by a detailed work plan, overseen and monitored by the Safeguarding Adults Committee, with examples being:

- The production of a Learning Disability and Autism Strategy.
- Autism awareness week 27th March – 2<sup>nd</sup> April – Communication sent to all staff to raise awareness regarding ‘reasonable adjustments’. Display Boards information also available in the Education Centre
- Working with external partners as well as the Hospital Learning Disability Champions to utilise Learning Disability Awareness Week 19<sup>th</sup> – 25<sup>th</sup> June 2017.
- Currently reviewing the Learning Disability champion role in supporting the raising of awareness of this and Autism in key departments.
- Learning Disability awareness training. Core skills education and training framework published by Health Education England. 2016.
- Tier 2 training recommended targeting Learning Disability Patient Champions. Patient Champion event 3<sup>rd</sup> April “Parents and Carers as partners in Learning Disability Support” with a Key Speaker, the Chair of the Dorset Parent Carer Council
- Although not mandatory, Learning Disability awareness is included in all staff induction sessions. This now includes a section within the newly launched Essential Skills e- book.
- The trust participates in the Learning Disability Mortality Review Programme (LeDeR) and notify programme of any deaths of people with a learning disability within Dorset County Hospital. Presentation regarding LeDeR to the Hospital Mortality Surveillance Committee has been arranged.
- Work to improve the information and resources available to staff, patients and relatives in liaison with other key departments in the Trust relating to the support of people with a learning disability and or autism. This currently includes updating the staff intranet pages for Learning Disability and Autism, as well as Mental Capacity Act and Deprivation of Liberty Safeguards.
- Quarterly Safeguarding Adults Audit has been revised and includes a section on supporting people with learning disability and / or autism. To be piloted from April 2017.

The Trust believes that the detailed work plan in this area is addressing the requirements needed. This will now be monitored through the internal Quality Committee.

## **Patient Experience – Advanced communication skills for staff supporting those at the End of Life**

Goal 2016-2017:

We will work with the Gold Standards Framework team to deliver a bespoke model of education that suits the needs of our staff supporting those at the end of life.

### **What are advanced communication skills?**

Communication involves getting information from one person to another person. Yet even this is not a complete definition because communicating effectively involves having that information relayed while retaining the same content and context. If one piece of information is stated, yet another piece of information is heard then this is not communication.

Advanced communication skills take the basic skills of communication and frame them within a general understanding of how the communication process works. This is why advanced communication skills are, in essence, leadership skills. They allow staff access to ways to guide and direct communication between themselves and other people. This is never as important as at the end of life.

### **How did we perform?**

The End of Life Care Education group (a sub group of the End of life Committee) developed a proposal for end of life care education for the trust for 2016-2017.

There were 4 aspects to this education programme:

- Communication skills
- Topic of the month
- Online Training
- Non clinical Staff training

### **Education and Training**

There were two communication skills training programmes delivered.

1. Communication skills for all clinical staff
2. Communication skills in Advance Care Planning for Consultant Staff.

#### **1. Communication skills for clinical staff**

There was a one day course delivered by the EOLCF or palliative care nurse and chaplain. It included teaching on the SPIKES 6 step communication tool and listening skills and used a combination of reflection, videos and role play.

Number attending	Staff attending		Feedback (summarised)
36	HCA	8	Excellent
	Staff nurse	12	Extremely likely/ likely to recommend
	Sister	5	Role play extremely/ very helpful
	Student	4	Very satisfied overall:
	Other	7	Very satisfied with content detail:

## 2. Communication Skills in Advance Care Planning for Consultants

Two teaching sessions were delivered during time allocated for mandatory clinical governance half days. The first session was 3 hours long and following feedback, the content was revised and the time reduced to 2 hours for the second session. The sessions were delivered by an external communication skills trainer, the palliative care consultant, and 2 palliative care nurses/ End Of Life Care Facilitator. It included teaching on the national context, group discussion, techniques and interactive rehearsal.

Number attending

Feedback

60

feedbacks received (4 domains rated on a 1-5 scale):

	1-2	3	4-5
How useful was the workshop?	23%	41%	36%
How likely are you to recommend it?	27%	41%	32%
Was the role play helpful and realistic?	29%	38%	33%

The communication skills for clinical staff days will continue to run. There are challenges in terms of staff being able to attend, with significantly more staff signing up than there are actually in attendance. Two sessions had to be cancelled due to lack of numbers. As part of the future education programme a variety of ways to bring communication skills and end of life care training to staff will be considered.

There are no plans to continue the consultants communication skills training in advance care planning. However further educational opportunities for specific training will be explored, for example several consultants highlighted issues around DNACPR (do not attempt resuscitation) conversations and requested further training in this area. These opportunities support our recently published End of Life Care strategy.

# End of Life Care Strategy

2017-2022



## Patient Experience – Timely and Compassionate Response to Complaints

Goal 2016-2017:

We will contact all patients or relatives who make a complaint and agree a timescale in which to work. Our target will be to achieve this agreed timescale on 95% or more occasions.

### What is a timely response important?

Complaints are an important way for the management of an organisation to be accountable to the public, as well as providing valuable prompts to review organisational performance and the conduct of people that work within and for it.

A complaint is an expression of dissatisfaction made to or about an organisation, related to its products, services or staff.

An effective complaint handling system provides three key benefits to an organisation:

- It resolves issues raised by a person who is dissatisfied in a timely and effective way;
- It provides vital information that can lead to improvements in service delivery, which over the last year we have used to improve our services in relation to End of Life Care;
- Where complaints are handled properly, a good system can improve confidence in an organisation's administrative processes.



## How did we perform?

Although a lot of work has been undertaken in the last year around improving the management of complaints, early resolution of factors causing concern and in particular improving the timeliness and compassion of responses; the results at end of year show that improvement in timeliness has not really been as successful as hoped, but rather has varied from month to month. There has been no sustained improvement in complaint timeliness.

There are likely to be a number of reasons for this, including staff absence among the staff responsible for investigating and responding to complaints, key members of staff leaving the Trust, and increased numbers of complaints received depending on time of year. Additionally, targets changed as the year progressed, and so it has been challenging to report accurately, particularly on timescales.

## Trust wide Performance

Percentage of complaints responded to within agreed timescales

Threshold	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
100% - Green 90% - 99% - Amber Under 90% - Red	42.0 %	72.0 %	68.0 %	57.0 %	52.0 %	52.0 %	48.0 %	40.0 %	40.0 %	48.0 %	62.0 %	N/A

### Percentage of Complaints responded to within target response time by Division

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
<b>Medicine</b>	14%	83%	73%	50%	55%	46%	50%	41%	50%	38%	83%	To follow
<b>Surgery</b>	80%	60%	68%	66%	50%	57%	41%	40%	20%	60%	60%	To follow
<b>Family</b>	n/a	n/a	80%	100%	50%	0%	43%	100%	33%	50%	0%	To follow
<b>Clinical &amp; Scientific</b>	n/a	n/a	0%	100%	100%	100%	50%	0%	50%	66%	0%	To follow

A comprehensive action plan has been developed to try to address the issue of complaints management improvement as a whole.

This action plan is aimed at streamlining each step of the complaints process, with comprehensive training and materials being developed and made available for staff responsible for investigation and response to complaints.

The action plan has been developed in time to coincide with the new divisional restructure, governance and performance framework. The action plan including the roll out of the complaints module of DatixWeb (the complaints reporting system) will quickly become embedded among staff and will show a sustained improvement in timeliness within a fairly short period of time. Assurance will be sought at regular stages to ensure that the action plan is working as planned.

The monthly divisional performance reviews will include complaints management within the quality section of the meeting.

The Trust also uses a combination of all other feedback (surveys, Friends and Family test, NHS Choices) to ensure that it is able to triangulate all sources and drive service improvements.

As the standards required for this priority have not been achieved, this remains a quality improvement for the forthcoming year 2017/18.

## Risk Assessment Framework and Single Oversight Framework Indicators

The following five indicators are a pre-requisite of the Risk Assessment Framework and the Single Oversight Framework to be included by Acute Trusts.

**RTT** - In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.

**ED 4 hour target** - A four-hour target in emergency departments was introduced by the Department of Health for National Health Service acute hospitals in England to state that at least 95% of patients attending an A&E department must be seen, treated, and admitted or discharged in under four hours.

**62 day wait** - All patients who have been referred by their GP or by a dentist on a suspected cancer pathway should receive their first definitive treatment within 62 days of referral receipt or a maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer.

Indicator	Standard	2012/13	2013/14	2014/15	2015/16	2016/17
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	92%	95.5%	94.9%	93.7%	92.1%	87.6%
Maximum ED waiting time of 4 hours from arrival to admission/transfer/ discharge	95%	96.5%	94.7%	94.9%	94.1%	93.2%
62 day wait for first treatment from an urgent GP referral for suspected cancer	95%	93.4%	88.4%	85.5%	81.7%	86.1%
62 day wait for first treatment following a NHS Cancer Screening Service referral	90%	96.8%	96.0%	98.2%	94.9%	94.9%
C-Diff hospital acquired cases (post 72 hours)	<14	22	27	8	10	7

## Annex 1 Statement from Commissioners, Local Healthwatch and Overview and Scrutiny Committees



Healthwatch Dorset comment on Dorset County Hospital NHS Foundation Trust Quality Account 2016/17

As the independent voice for patients and the public, Healthwatch Dorset is committed to ensuring local people are involved in the improvement and development of health and social care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts, which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers). In Dorset, this translates to Quality Accounts from five NHS Trusts.

Each document is lengthy and each year we spend many hours reading the draft Accounts and giving suggestions on how they could be improved to make them meaningful for the public. Each year we comment on what each Trust is doing to involve patients and the public and how it might improve the ways in which it engages and listens to all the communities it serves. But continually and continuously through the year we are already, in our day-to-day work, monitoring and commenting on the quality of services of our local NHS providers.

This year we have decided not to spend the hours necessary to read each Quality Account and compose a special commentary on it. Whilst we appreciate that the process of Quality Accounts is imposed on the Trusts, we do not believe it is a process that is accessible to patients or their families, friends or carers, in its current format. We have limited resources and we want to focus them on standing up for and promoting the rights of patients and the public and on supporting and holding Trusts to account for the ways in which they involve patients and the public.

We will continue to provide feedback to the Trust, as appropriate, throughout the year through a variety of channels to improve the quality, experience and safety of its patients, their families and the wider population of Dorset.

Healthwatch Dorset 2017

---

Freepost RTJR-RHUU-XBLH Healthwatch Dorset 896 Christchurch Road BH7 6DL



**Dorset  
Clinical Commissioning Group**

5 May 2017

Nicky Lucey  
Director of Nursing and Quality  
Dorset County Hospital NHS Foundation  
Trust  
Williams Avenue  
Dorchester  
Dorset DT1 2JY

Vespasian House  
Barrack Road  
Dorchester  
Dorset  
DT1 1TG

Tel: 01305 368900  
Fax: 01305 368947  
www.dorsetccg.nhs.uk

Dear Nicky

Re: Quality Account 2016/17

Thank you for asking NHS Dorset Clinical Commissioning Group (CCG) to review and comment on your Quality Accounts for 2016/17. Please find below the CCG's statement for inclusion in the final document:

*"Dorset CCG welcomes the opportunity to provide this statement on Dorset County Hospital NHS Foundation Trust's Quality Account. We have reviewed the information contained within the Account and can confirm that the information is accurate where available to us as part of existing contract/performance monitoring discussions."*

*During the year progress has been made in achieving a sustained reduction in hospital acquired pressure ulcers and improving awareness and services for people with a learning disability. The CCG also acknowledges that the Trust is working hard to improve governance and welcomes the progress being made in creating a more structured process to provide assurance of both safety and quality measures. It is also encouraging to see the Trust has a number of new initiatives in 2017/18 including improving support from hospital volunteers and promoting the health and wellbeing of patients and staff.*

*We recognise that in addition to the successes identified, progress remains unresolved in relation to improved mortality surveillance and Electronic Discharge Summaries (EDS) and we would expect that the renewed focus in the coming year will enable the achievement of these objectives.*

*As Commissioners we look forward to working with the Trust during 2017/18 and we commend the fact that there is a willingness to work collaboratively to improve the experience for the population which the Trust serves. We look forward to the Trust demonstrating the improvements in patient care they will be applying over the coming year."*

Supporting people in Dorset to lead healthier lives

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

Yours sincerely



Mrs Sally Shead  
Director of Nursing & Quality

### **DCHFT Lead Governor Commentary on the Trust Quality Report 2016-2017**

As Lead Governor for the trust I have been asked to provide a commentary on the trust's annual quality report.

The report details quality against 9 different standards. In general the report demonstrates improvements in the quality against these standards although in some instances the data is not of sufficient quality to demonstrate an improvement. I have detailed comments relating to each standard below.

#### **1 Hospital Acquired Pressure Ulcers**

Sufficient data to demonstrate a marked improvement against this standard.

#### **2 Improved Mortality Surveillance and Reducing Variation**

A framework for how the trust is going to do this is detailed. No data is presented in the report. This item remains in the quality report for 2018.

#### **3 Reducing the incidence of Severe Sepsis.**

Some detail of education delivered to achieve this is presented. Some data is presented on sepsis screening rates in ED. Screening rates are only 70% but no actual numbers are given. No data on antibiotic administration is detailed.

This remains a quality priority for the trust and hopefully more comprehensive data will be presented in the 2018 report.

#### **4 Implementation of improved discharge process**

This quality standard looks at the number of delayed discharges the trust has and ways in which the Trust has been trying to reduce the number of delayed discharges through a number of projects and agencies. Clearly this is not an easy problem to solve.

The data presented shows that we are above the national target of 3.5% for delayed transfers of care with the trusts running at around 5% (NHSE methodology).

The data shows a marginal improvement in 2016/17 compared to the previous year.

#### **5 Increased Percentages of Electronic Discharge Summaries within 24hrs**

Data is presented for 2016 and 2017. There has been a slight improvement in the percentage which now runs at around 72%. There is however still a significant problem to be solved here. There are some system issues and there is an action plan to resolve these.

This issue remains in the quality account for 2018



**6 Improving Availability and Accessibility of Information to Patients**

The trust has been aiming to comply with the NHS England Information standard. An NHS England visit in 2017 confirmed that we now meet its standards. No data has been presented on the availability of patient information.

**7 Improved services for patients with learning disabilities**

The report details a number of initiatives to achieve the above. A considerable amount of work and effort has gone in to this area.

**8 Advanced communication skills for staff supporting those at the end of life**

The report details education and training that was delivered to staff to and try and improve this aspect of patient care.

**9 Timely and compassionate response to complaints**

The report demonstrates a huge variation from month to month and between different divisions in responding to complaints. Overall the percentage is far below the 95% target. The trust is addressing the issues around the poor response to complaints and this will remain in the quality report for 2018.

Dr Duncan Farquhar-Thomson

Lead Governor DCHFT





**Official - sensitive**

Neal Cleaver  
Deputy Director of Nursing  
Dorset County Hospital  
NHS Foundation Trust  
Williams Avenue  
Dorchester  
Dorset  
DT1 2JY

Adult and Community Services  
County Hall, Colliton Park  
Dorchester  
Dorset DT1 1XJ

Telephone: 01305 224388

Fax: 01305 224325

**We welcome calls via text Relay**

Email: [a.p.harris@dorsetcc.gov.uk](mailto:a.p.harris@dorsetcc.gov.uk)

Website: [www.dorsetforyou.com](http://www.dorsetforyou.com)

Date: 9 May 2017

My ref: DCH QA Letter 16/17

Your ref:

Dear Neal

**Quality Account 2016/17**

On behalf of the Dorset Health Scrutiny Committee, please find attached the commentary that we would like to submit following the opportunity to meet with the Dorset County Hospital NHS Foundation Trust over the past year and in particular on 3 May 2017, to review the progress of your Quality Account.

**Dorset Health Scrutiny Committee commentary for Dorset County Hospital NHS Foundation Trust, May 2017:**

Three Members of the Dorset Health Scrutiny Committee are appointed annually to form a Task and Finish Group which meets twice per year with representatives of the Dorset County Hospital NHS Foundation Trust on an informal basis, to discuss the progress being made in improving quality and performance. The annual Quality Account and Report for 2016/17 shared with the Group demonstrates a positive year for the Trust, and the Committee's representatives offer the following comments on items of particular interest or note:

- Members welcome the explanatory notes within the Quality Report, which add to the understanding of the formal content;
- With regard to patient safety, progress in reducing the incidence of pressure ulcers has been very good and Members wish to congratulate the Trust for this;
- With regard to mortality surveillance, the focus on greater involvement with families and transparency to improve the 'quality' of death, as well as investigating unexplained death, is felt to be important by Members;
- The work undertaken to improve the recognition and early treatment of sepsis is to be commended, and Members support the plans for further work in this area. The poster designed by staff demonstrates an encouraging level of engagement which should help the Trust to reach its target;
- Delayed transfers of care are of particular interest, given the links with adult social care and the Local Authority. Members acknowledge the difficulties in accessing resources to support individuals who are ready for discharge (either to community hospitals, residential care settings or back home) and commend the work the Trust is undertaking in partnership with other agencies to tackle this;

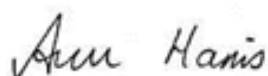
Helen Coombes, Interim Director for Adult and Community Services  
Working together for a strong and successful Dorset



- It was disappointing to learn that progress in the timely exchange of electronic discharge summaries has not been as successful as the Trust would wish. Members hope that this can be improved in the coming year;
- Mixed feedback from staff as to the value of communication skills training within end of life care education is also disappointing. However, Members were reassured to hear that changes to training programmes have been made to this valuable area of work as a result;
- The lack of improvement in timely response to complaints was noted, but Members were pleased to hear that the number of compliments received far exceeds the number of complaints, and suggest that this information is included in the Report;
- With regard to the inspection of the Trust by the Care Quality Commission in March 2016, Members recognised that the Trust was already aware of the areas of service that required improvement and appreciates the reports on this matter which have been presented to Dorset Health Scrutiny Committee. Members also recognise the financial pressures on the NHS and Local Authorities which are beyond their control, and supports the efforts of the Trust to deliver their Action Plan for improvement in the future.

Overall, the Dorset Health Scrutiny Committee has found Dorset County Hospital NHS Foundation Trust to be open and cooperative in its meetings and communications with the Committee, and Members look forward to a continuation of the constructive relationship that has been developed in recent years.

Yours sincerely



**Ann Harris**  
Health Partnerships Officer

**On behalf of Dorset Health Scrutiny Committee**

CC:

Patricia Miller, Chief Executive, Dorset County Hospital NHS Foundation Trust

Cllr Ronald Coatsworth, Chair Dorset Health Scrutiny Committee

Helen Coombes, Interim Director, Adult and Community Services

Nicky Lucey, Director of Nursing and Quality, Dorset County Hospital NHS Foundation Trust

## Annex 2 Statement of Directors' Responsibility for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to May 2017
  - papers relating to quality reported to the board over the period April 2016 to May 2017
  - feedback from commissioners dated 05/05/2017
  - feedback from governors dated 09/05/2017
  - feedback from local Healthwatch organisations dated 19/04/2017
  - feedback from Overview and Scrutiny Committee dated 09/05/2017
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27/07/2016. (The 2016/17 Annual Complaints report is currently in draft and will be made available to the public on the Trusts website)
  - the latest national patient survey 27/01/2017
  - the latest national staff survey 07/03/2017
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated April 2017
  - CQC inspection report dated 16/08/2016

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Mark Addison  
Chairman  
22 May 2017

Patricia Miller  
Chief Executive  
22 May 2017

**INDEPENDENT AUDITOR'S LIMITED ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS OF DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT**

We have been engaged by the Council of Governors of Dorset County Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Dorset County Hospital NHS 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 national priority indicators as mandated by Monitor:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- percentage of patients with a total time in A&E of four hours or less 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 preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS improvements.

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 External Assurance for Quality Reports for Foundation Trusts 2016/17 issued by NHS Improvement in February 2017 ("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 supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

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 quality report to confirm it was consistent with the following documents:

- Board minutes and papers for the period April 2016 to May 2017
- Papers relating to Quality Report reported to the Board since April 2016
- Feedback from Dorset CCG (lead commissioner) dated 5 May 2017
- Feedback from the Trust's lead governors dated May 2017.
- Feedback from healthwatch Dorset dated May 2017
- Feedback from the Dorset Health Scrutiny Committee dated 9 May 2017
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2016.
- The inpatient survey 2016 published in February 2017.
- The 2016 national staff survey
- Care Quality Inspection, dated 16 August 2016
- The Head of Internal Audit's annual Report and opinion over the Trust's control environment dated April

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 Dorset County Hospital NHS Foundation Trust as a body, to assist the Council of Governors in Dorset County Hospital 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 that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Dorset County Hospital NHS Foundation Trust for our work or this report except where terms are expressly agreed and with our prior consent in writing.



### Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- 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 impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision 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’.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Dorset County Hospital NHS Foundation Trust.

## **Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Detailed Requirements for External Assurance for Quality Reports for Foundation Trusts 2016/17 issued by NHS Improvement in February 2017; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

**Greg Rubins**

**For and on behalf of BDO LLP, appointed auditor**

Southampton, UK

22 May 2017



## Foreword to the Accounts

These accounts for the year ended 31<sup>st</sup> March 2017 have been prepared by Dorset County Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and comply with the annual reporting guidance for NHS Foundation Trusts within the Department of Health Group Accounting manual 2016/17.

Dorset County Hospital NHS Foundation Trust's Annual Report and Accounts are presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006.

Patricia Miller  
Chief Executive  
22 May 2017

## Independent auditor's report to the Council of Governors and Board of Directors of Dorset County Hospital NHS Foundation Trust

We have audited the financial statements of Dorset County Hospital NHS Foundation Trust (the Trust) for the year ended 31 March 2017 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the NHS Foundation Trust Annual Reporting Manual 2016/17 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

### Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of affairs of Dorset County Hospital NHS Foundation Trust's affairs as at 31 March 2017 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17; and
- have been prepared in accordance with the National Health Service Act 2006.

### Emphasis of matter – going concern

We draw attention to note 1 to the financial statements which sets out the Directors' assessment of the financial position of the Trust in the context of the National Health Service framework in which it operates and their conclusion that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern. Our opinion is not qualified in respect of this matter.

### Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of the Chief Executive's Responsibilities as the Accounting Officer, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they 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 Financial Reporting Council's (FRC's) Ethical Standards for Auditors.

This report is made solely to the Council of Governors of Dorset County Hospital NHS Foundation 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 Dorset County Hospital NHS Foundation Trust those matters we are required to state to it 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 NHS Foundation Trust as a body, for our audit work, for this report or for the opinions we have formed.

### Scope of our audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to Dorset County Hospital NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

### **Our assessment of risks of material misstatement**

In arriving at our opinion on the financial statements, the risks of material misstatement that had the greatest effect on our audit, and the principal procedures we applied to address them, were as set out below.

<b>Risk</b>	<b>How the scope of our audit responded to the risk</b>
<p><b>NHS revenue recognition</b></p> <p>NHS revenue is the most significant income stream for the Trust and is at most risk from material error and fraud.</p> <p>There is a risk that NHS revenue may be materially incomplete, inaccurate or inappropriately recognised.</p>	<p>Our response:</p> <ul style="list-style-type: none"> <li>• We reviewed and considered the design and implementation of controls in place for the revenue system covering NHS income streams.</li> <li>• We reviewed the signed contracts for the Trust's significant commissioners and verified a sample of variations to these contracts.</li> <li>• We reviewed a sample of credit notes received after year end to ensure they were valid.</li> <li>• We ensured that all NHS income was accounted for in line with the revenue recognition policy adopted by the Trust.</li> <li>• We reviewed the outcomes of the national Intra-NHS Agreement of Balances process to ensure that all NHS income and receivables were confirmed as matched and for any mismatches exceeding £250k and agreed to supporting evidence to corroborate the Trust's position and accounting treatment.</li> </ul>
<p>A significant proportion of the Trust's income is received through service level agreements, which are based on planned levels of patient activity, with organisations responsible for the commissioning of healthcare services. There is a risk of fraud, due to pressure on management to achieve financial targets, in recognising this revenue through inappropriate use of accounting policies, failure to apply the Trust's stated accounting policies or inappropriate use of estimates in calculating this revenue.</p>	<p>In responding to this risk, our audit procedures included:</p> <ul style="list-style-type: none"> <li>• Consideration of the accounting policies applied by the Trust in the recognition of income</li> <li>• Reviewing the design and implementation of controls in relation to the NHS revenue and patient activity system</li> <li>• Reviewing NHS income reported to determine if it was in line with our understanding of the Trust and prior year financial statements</li> <li>• Agreeing a sample of NHS receipts, invoices and credit notes raised around the year end to determine if they had been accounted for in the correct period</li> <li>• Investigation of differences identified as a result of the NHS agreement of balances and transactions exercise which aims to ensure agreement of balances and transactions between NHS and other government bodies</li> <li>• Reviewing all income items tested to determine if they were accounted for in line with the revenue recognition policy adopted by the Trust</li> </ul>

Risk	How the scope of our audit responded to the risk
<p>The Trust has faced increasing financial challenges during the year and is currently regarded as being at a material level of financial risk in respect of the continuity of services. There is also an increased risk that the financial pressures arising from this situation will lead to management bias in accounting estimates and material misstatement in the financial statements.</p>	<p>In responding to this risk, our audit procedures included:</p> <ul style="list-style-type: none"> <li>• Heightened scepticism was applied throughout all of our testing, particularly around accounting estimates and significant judgements applied</li> <li>• Scrutinising the going concern assessment completed by management and those charged with governance</li> <li>• Challenging forecasts and assumptions used in the Trust's future financial plans and cash flow models.</li> <li>• Considering relevant findings of Internal Audit arising from their work relating to the financial position of the Trust and its financial management arrangements, and the overall Head of Internal Audit opinion.</li> <li>• Material estimates within the financial statements were reviewed and agreed to supporting calculations. Key assumptions included within the estimates were reviewed to confirm they are in line with industry expectations and historic results.</li> <li>• Material estimates were also reviewed for evidence of bias.</li> </ul>
<p><b>Financial Sustainability</b></p> <p>The Trust recorded a deficit of £1.1m for the year ended 31 March 2017, and has forecast a deficit of £2.9m for the year ended 31 March 2018. The Trust is currently scored by NHS Improvement as presenting the highest level of financial risk possible in its grading system for Foundation Trusts. There is a significant risk to the Trust's ability to achieve financial sustainability in the medium term.</p>	<p>Our response:</p> <ul style="list-style-type: none"> <li>• We considered the Trust's financial performance in the year to 31 March 2017, and achievement of control totals and planned Cost Improvement Programme schemes.</li> <li>• We reviewed the Trust's governance arrangements for financial and Cost Improvement Programme performance management.</li> <li>• We tested the feasibility of profit and loss and cashflow forecasts for the year ended 31 March 2018.</li> <li>• We assessed the availability of additional borrowing under the Trust's current borrowing facilities.</li> <li>• We reviewed the Trust's arrangements for engaging and working with its local partners to develop transformation plans designed to achieve financial stability in the medium term.</li> </ul>

## Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in both planning the scope of our audit and in evaluating the results of our work.

The materiality for the financial statements as a whole was set at £3.186 million. This has been determined with reference to the benchmark of gross expenditure (of which it represents 1.85%) which we consider to be one of the principal considerations for the Council of Governors in assessing the financial performance of the Trust.

We agreed with the Audit Committee to report to it all material corrected misstatements and all uncorrected misstatements we identified through our audit with a value in excess of £64,000, in addition to other audit misstatements below that threshold that we believe warranted reporting on qualitative grounds.

## Opinion on other matters on which we are required to report

In our opinion:

- the parts of the remuneration report subject to audit in the Annual Report have been properly prepared in accordance with the Foundation Trust Annual Reporting Manual; being:
  - the fair pay multiple
  - the table of salaries and allowances of senior managers
  - the table of pension benefits of senior managers
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

## Matters on which we report by exception – Use of Resources

The National Audit Office's Code of Audit Practice requires us to report to you if we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Our assessment of arrangements is made by

reference to the overall criterion: *In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.*

Dorset County Hospital NHS Foundation Trust has a general duty under paragraph 63 of Chapter 5 of the National Service Act 2006 to exercise the functions of the Trust effectively, efficiently and economically. Paragraph 1 of Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice require that we satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice requires us to report to you if we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

For the year ended 31 March 2017 the Trust has reported a deficit of £1.1m, after taking account of £5.3m of Sustainability and Transformation income. This follows a deficit in 2015/16 of £5.5m. The Trust has been working closely with its partners and NHSI to develop a financially sustainable position and in December 2016 prepared an Operational Plan which was approved by the Board. The Operational Plan contained a financial plan for the period from 1 April 2017 to 31 March 2019.

The financial plan contains significant cost reductions in both 2017/18 and 2018/19 (£8.7 million and £5.3 million respectively) but this does not fully address the financial position where deficits are forecast for both 2017/18 and 2018/19 of £2.9 million and £2.7 million respectively.

Accordingly, the Trust does not yet have a financially sustainable position. The longer term sustainability of the Trust will be dependent on the successful delivery of the Sustainability Transformation Plan (STP), including improved partnership working across the Dorset health economy. This is at an early stage but the framework is being put in place to achieve this.

Given the uncertainties around the Trust's short term and long term financial sustainability we have been unable to satisfy ourselves that Dorset County Hospital NHS Foundation Trust has made proper

arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017 with regards to sustainable resource deployment.

**Other Matters on which we report by exception**

We have nothing to report in respect of the following:

Under the ISAs (UK and Ireland), we report to you if, in our opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements, or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the NHS Foundation Trust acquired in the course of performing our audit; or
- is otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

Under the National Audit Office's Code of Audit Practice we report to you if we have exercised special auditor powers in connection with the issue of a public interest report or we have made a referral to the regulator under Schedule 10 of the National Health Service Act 2006.

Under the National Audit Office's Code of Audit Practice 2015 we are required to report

to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the Annual Governance Statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual and is not misleading or inconsistent with other information that is forthcoming from the audit; or
- the Quality Report has been prepared in accordance with the detailed guidance issued by NHS Improvement.

**Audit certificate**

We certify that we have completed the audit of the financial statements of Dorset County Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice 2015.

Greg Rubins

for and on behalf of BDO LLP

Registered auditor

Southampton, UK

22 May 2017

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

## Statement of Comprehensive Income for the year ended 31<sup>st</sup> March 2017

	Note	2016/17 £000	2015/16 £000
Operating income	3	171,203	159,931
Operating expenses	6	<u>(169,575)</u>	<u>(162,890)</u>
<b>Operating surplus/(deficit)</b>		<b>1,628</b>	<b>(2,959)</b>
<b>Finance costs:</b>			
Finance income	11	91	77
Finance expenses - financial liabilities	12	(105)	(103)
Finance costs - unwinding of discount on provisions		(1)	(7)
PDC dividends payable		<u>(2,693)</u>	<u>(2,424)</u>
<b>Net finance costs</b>		<b>(2,708)</b>	<b>(2,457)</b>
Losses of disposal of assets	13	(42)	(86)
<b>Deficit for the year</b>		<b>(1,122)</b>	<b>(5,502)</b>
<b>Other comprehensive income</b>			
Impairment of property, plant and equipment		(3,453)	(502)
Revaluation gains on property, plant & equipment		6,596	479
<b>Total comprehensive income for the year</b>		<b><u>2,021</u></b>	<b><u>(5,525)</u></b>

The notes on pages 174 to 203 form part of these accounts.



## Statement of Financial Position as at 31<sup>st</sup> March 2017

	Note	31 March 2017 £000	31 March 2016 £000
<b>Non-current assets</b>			
Intangible assets	15	4,347	3,545
Property, plant and equipment	16	92,110	90,756
Trade and other receivables	19.1	307	241
<b>Total non-current assets</b>		<b>96,764</b>	<b>94,542</b>
<b>Current assets</b>			
Inventories	18	3,026	3,143
Trade and other receivables	19.1	9,741	5,646
Cash and cash equivalents	20	4,427	4,018
<b>Total current assets</b>		<b>17,194</b>	<b>12,807</b>
<b>Current liabilities</b>			
Trade and other payables	21	(14,808)	(10,304)
Borrowings	22	(169)	(181)
Provisions	23	(88)	(95)
Other liabilities	24	(961)	(916)
<b>Total current liabilities</b>		<b>(16,026)</b>	<b>(11,496)</b>
<b>Total assets less current liabilities</b>		<b>97,932</b>	<b>95,853</b>
<b>Non-current liabilities</b>			
Borrowings	22	(4,889)	(4,781)
Provisions	23	(387)	(437)
<b>Total non-current liabilities</b>		<b>(5,276)</b>	<b>(5,218)</b>
<b>Total assets employed</b>		<b>92,656</b>	<b>90,635</b>
<b>Financed by taxpayers' equity:</b>			
Public dividend capital		85,107	85,107
Revaluation reserve		32,370	29,251
Income and expenditure reserve		(24,821)	(23,723)
<b>Total taxpayers' equity:</b>		<b>92,656</b>	<b>90,635</b>

The financial statements on pages 170 to 203 were approved by the Board on 22 May 2017 and signed on its behalf by:

Patricia Miller  
Chief Executive  
22 May 2017



## Statement of Changes in Taxpayers' Equity

	<b>Total</b>	Public Dividend Capital (PDC)	Revaluation Reserve	Income and Expenditure Reserve
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>Taxpayers' equity at 1 April 2016</b>	<b>90,635</b>	<b>85,107</b>	<b>29,251</b>	<b>(23,723)</b>
Deficit for the year	(1,122)	-	-	(1,122)
Impairment losses on property, plant and equipment	(3,453)	-	(3,453)	-
Net gain on revaluation of property, plant and equipment	6,596	-	6,596	-
Transfer to the income and expenditure account in respect of assets disposed of	-	-	(9)	9
Transfers between reserves	-	-	(15)	15
<b>Taxpayers' equity at 31 March 2017</b>	<b>92,656</b>	<b>85,107</b>	<b>32,370</b>	<b>(24,821)</b>
<b>Taxpayers' equity at 1 April 2015</b>	<b>96,010</b>	<b>84,957</b>	<b>29,298</b>	<b>(18,245)</b>
Deficit for the year	(5,502)	-	-	(5,502)
Impairment losses on property, plant and equipment	(502)	-	(502)	-
Net gain on revaluation of property, plant and equipment	479	-	479	-
Public Dividend Capital received	750	750	-	-
Public Dividend Capital repaid	(600)	(600)	-	-
Transfer to the income and expenditure account in respect of assets disposed of	-	-	(5)	5
Transfers between reserves	-	-	(19)	19
<b>Taxpayers' equity at 31 March 2016</b>	<b>90,635</b>	<b>85,107</b>	<b>29,251</b>	<b>(23,723)</b>

The Revaluation Reserve consists of £32,370k (£29,251k at 31 March 2016) relating to property, plant and equipment.

## Statement of Cash flows for the year ended 31<sup>st</sup> March 2017

	2016/17 £000	2015/16 £000
<b>Cash flows from operating activities</b>		
Operating surplus/(deficit)	1,628	(2,959)
Depreciation and amortisation	5,166	6,408
Net impairments	(16)	(14)
Income recognised in respect of capital donations (cash and non-cash)	(377)	(1,033)
(Increase)/decrease in trade and other receivables	(4,180)	521
Decrease/(increase) in inventories	117	(76)
Increase/(decrease) in trade and other payables	4,281	(89)
Increase/(decrease) in other liabilities	45	(109)
(Decrease) in provisions	(58)	(104)
<b>Net cash generated from operations</b>	<b>6,606</b>	<b>2,545</b>
<b>Cash flows from investing activities</b>		
Interest received	91	77
Purchase of intangible assets	(1,883)	(1,174)
Purchase of property, plant and equipment	(1,839)	(3,521)
Sales of property, plant and equipment	9	83
Receipt of cash donations to purchase capital assets	370	577
<b>Net cash used in investing activities</b>	<b>(3,252)</b>	<b>(3,958)</b>
<b>Cash flows from financing activities</b>		
Public dividend capital received	-	750
Public dividend capital repaid	-	(600)
Capital element of finance lease obligations	(209)	(263)
Interest Paid	(97)	(97)
Interest element of finance lease obligations	(8)	(6)
PDC dividends paid	(2,631)	(2,429)
<b>Net cash used in financing activities</b>	<b>(2,945)</b>	<b>(2,645)</b>
<b>Increase/(decrease) in cash and cash equivalents</b>	<b>409</b>	<b>(4,058)</b>
<b>Cash and cash equivalents at 1 April</b>	<b>4,018</b>	<b>8,076</b>
<b>Cash and cash equivalents at 31 March</b>	<b>4,427</b>	<b>4,018</b>

# Notes to the Financial Statements

## 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 GAM 2016/17 issued by the Department of Health. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

### Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

### 1.1 Critical accounting judgements and key sources of estimation uncertainty

In the preparation of the financial statements, the Trust is required to make estimates and assumptions that affect the application of accounting policies and the carrying amounts of assets and liabilities. These estimates and assumptions are based on historical experience and other factors that are considered to be relevant. Actual outcomes may differ from prior estimates and the estimates and underlying assumptions are continually reviewed.

The key sources of estimation uncertainty which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities are:

#### Valuation of land and buildings

Land and buildings are included in the Trust's statement of financial position at current value in existing use. The assessment of current value represents a key source of uncertainty. The Trust uses an external professional valuer to determine current value in existing use, using modern equivalent asset value methodology and market value for existing use for non-specialised buildings.

#### Depreciation of property, plant and equipment and amortisation of computer software

The Trust exercises judgement to determine the useful lives and residual values of property, plant and equipment and computer software. Depreciation and amortisation is provided so as to write down the value of these assets to their residual value over their estimated useful lives.

### 1.2 Consolidation

The Trust has established that, as it is the corporate trustee of Dorset County Hospital NHS Foundation Trust Charitable Fund, it effectively has the power to exercise control of this charity so as to obtain economic benefits. However the assets, liabilities and transactions are immaterial in the context of the Trust and therefore it has not been consolidated. Details of balances and transactions between the Trust and the charity are included in the related parties' notes.

### 1.3 Income

Income in respect of services provided is recognised when and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity, which is to be delivered in the following financial year, this 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.

### 1.4 Expenditure on employee benefits

#### 1.4.1 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.

### 1.4.2 Pension costs

Payments to defined contribution pension schemes (including defined benefit schemes that are accounted for as if they were a defined contribution scheme) are recognised as an expense as they fall due.

*NHS Pension Scheme:* Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://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.

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 operating expenses at the time the Trust commits itself to the retirement regardless of the method of payment.

The Foundation Trust does not have any employees that are members of the Local Government Superannuation Scheme and therefore does not pay employer contributions into this scheme.

### 1.4.3 Termination Benefits

Staff termination benefits are provided for in full when there is a detailed formal termination plan and there is no realistic possibility of withdrawal by either party.

## 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised to the extent that they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except when it results in the creation of a non-current asset such as property, plant and equipment.

## 1.6 Property, plant and equipment

### 1.6.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually it cost at least £5,000; or
- collectively has a cost of at least £5,000 and individually a cost of more than £250;
- the assets are functionally interdependent, with broadly simultaneous purchase dates, which are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building includes a number of components with significantly different asset lives. E.g. hospital wings, then these components are treated as separate assets and depreciated over their own useful economic lives.

The component parts of each significant Trust building are depreciated as a group, as permitted by IAS 16, unless a component has a significantly different UEL and is deemed by the Trust to be significant, in which case it is depreciated separately over its own economic useful life.

### 1.6.2 Measurement

*Valuation:* All property, plant and equipment are measured initially at cost, representing the cost 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 buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with

sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Non-specialised buildings – market value for existing use
- land and specialised buildings – Modern equivalent asset value

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Bilfinger GVA carried out the Trust valuation as professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Until 31<sup>st</sup> March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. Indexation ceased from 1<sup>st</sup> April 2008. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment, which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

The valuation as reported in the Statement of Financial Position at 31<sup>st</sup> March 2017 was assessed by the valuer of Bilfinger GVA, based on a desktop valuation survey completed in March 2017 following a full valuation in April 2016.

**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 expenses.

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 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) impairment charged to operating expenses; (ii) the balance in the revaluation reserve attributable to that asset before impairment.

An impairment that arises from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenses 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.

### 1.6.3 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 the 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 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

## 1.7 Intangible assets

### 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or arise from contractual or other legal rights. They are recognised only when 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.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Expenditure on development is capitalised only where all of the following have been demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset is identified;
- 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.

### 1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no

active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

## 1.8 Depreciation and amortisation

Freehold land is considered to have an infinite life and is not depreciated. Properties under construction are not depreciated until brought into use.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.



The following table details the useful economic lives currently used for the main classes of assets:

<b>Asset class</b>	<b>Useful economic life (years)</b>
Buildings excluding dwellings	19 – 67
Dwellings	45 – 78
Plant & machinery	3 – 15
Information technology	5 – 10
Furniture & fittings	5 – 15
Intangible assets	5 – 10

Property, plant and equipment which have been re-classified as 'held for sale' cease to be depreciated upon the re-classification.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

### 1.9 Donated 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 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.

### 1.10 De-recognition

Assets intended for disposal are reclassified as 'Held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for sale'; and

- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not re-valued, except where the 'fair value less costs to sell' falls below the carrying amount. 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.

### 1.11 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'On-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent financial lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

### 1.12 Leases

#### 1.12.1 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 calculated by applying the implicit interest rate to the outstanding liability and 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.

### 1.12.2 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.

### 1.12.3 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.

### 1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using the 'first-in first-out' formula. These are considered to be a reasonable approximation to fair value due to the high turnover of stocks.

### 1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and

that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

### 1.15 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 that amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 0.7% in real terms, except for post-employment benefits provisions which use the HM Treasury's pension discount rate of 0.24% in real terms.

### 1.16 Clinical negligence costs

The NHS Litigation Authority (NHS LA) operates a risk pooling scheme under which the Foundation Trust pays an annual contribution to the NHS LA, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS LA is administratively responsible for all clinical negligence cases the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by the NHS LA on behalf of the Trust is disclosed at note 23.2 but is not recognised in the NHS Foundation Trust's accounts.

### 1.17 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 Foundation Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of any claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when the liability arises.

### 1.18 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, these are disclosed where an inflow of economic benefits is probable. The Trust currently has no contingent assets to disclose.



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.

### 1.19 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, (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirement laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

### 1.20 Financial instruments and financial liabilities

Financial assets are recognised when the Foundation Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

#### 1.20.1 Financial assets

Financial assets are classified into the following categories: Financial assets at fair value through income and expenditure; Held to maturity investments; 'Available for sale financial assets'; and 'Loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

The Foundation Trust did not during the period covered by these accounts hold any financial assets within the categories of: 'Financial assets at fair value through income and expenditure'; 'Held to maturity investments'; and 'Available for sale financial assets'.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

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. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

#### 1.20.2 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Foundation Trust becomes party to contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has expired or been paid.

Financial liabilities are initially recognised at fair value.

#### 1.20.3 Other financial liabilities

After initial recognition, 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 except for loans from the Department of Health which are carried at historic cost. The effective interest

rate is the rate that discounts exactly estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

### 1.21 Value Added Tax

Most of the activities of the 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.

### 1.22 Corporation Tax

The Foundation Trust is not liable to Corporation Tax for the following reasons:

Private patient activities are covered by section 14(1) of the Health and Social Care (Community Health and Standards) Act 2003 and not treated as a commercial activity and are therefore tax exempt; and

Other trading activities (including car parking and staff canteens) are ancillary to the core activities and are not deemed to be entrepreneurial in nature.

### 1.23 Foreign currencies

The Foundation Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the rates prevailing at that date. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

### 1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Foundation Trust has no beneficial interest in them. However they are disclosed in Note 30 to the accounts in accordance with the requirements of the HM Treasury's Financial Reporting Manual.

### 1.25 IFRS adoption impact

The DH GAM does not require the following standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 identified for implementation in 2018/19, and the Government implementation date for IFRS 16 still subject to HM Treasury consideration:

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 15 Revenue from contracts with customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations, which is in line with guidance contained in the DH GAM 2016/17.

### 1.26 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 general 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). The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

### 1.27 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

### 1.28 Going concern

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust recorded an operating deficit in 2015/16 of £5.5 million and is reporting a deficit of £1.1 million for the year ended 31 March 2017. The Trust anticipates incurring a further deficit of £2.9 million in delivering services in 2017/18 and will need to apply for Financial Support through a working capital loan anticipated to be to the value of £2.5 million. It anticipates this deficit position will continue during 2018/19 and that it may take some time before it can achieve financial balance on a sustainable basis. The Board of Directors have concluded that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern.

Nevertheless, the Directors have concluded that assessing the Trust on the going concern basis remains appropriate. The Trust has agreed contracts with its local commissioners for 2017/18 and services are being commissioned in the same manner for 2017/18 as in previous years and there are no discontinued operations. Similarly no decision has been made to transfer services or significantly amend the structure of the organisation at this time. The Board of Directors also has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health (NHS Act 2006,s42a) to continue to deliver the full range of mandatory services for the foreseeable future.

The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the accounts and has not included the adjustments that would result if it was unable to continue as a going concern. The assessment accords with the statutory guidance contained in the NHS Foundation Trust Annual Reporting Manual.

## 2. Segment analysis

The Trust has considered the requirements in IFRS 8 for segmental analysis. Having reviewed the operating segments reported internally to the Board, the Trust is satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- The nature of the products and services;
- The nature of the production processes;
- The type of customer for their products and services;
- The methods used to distribute their products or provide their services; and
- The nature of the regulatory environment.

The Trust therefore has just one segment, "healthcare". Analysis of income by different activity types and sources is provided in note 4.

### 3. Operating income

		Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
	Note		
Income from patient activities	4	152,103	146,886
Other operating income	5	19,100	13,045
<b>Total</b>		<b>171,203</b>	<b>159,931</b>

### 4. Income from patient care activities

4.1 Analysis by activity		Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
Elective income		35,065	34,751
Non-elective income		34,295	33,518
Outpatient income		21,943	21,690
A&E income		6,520	5,179
Other NHS clinical income		52,861	49,763
Additional income for delivery of healthcare		-	600
Private patient income		939	969
Other clinical income		480	416
<b>Total</b>		<b>152,103</b>	<b>146,886</b>
Income from Commissioner Requested Services		147,856	142,319
Income from non-Commissioner Requested Services		4,247	4,567
<b>Total</b>		<b>152,103</b>	<b>146,886</b>

The A&E income now includes income for Minor Injuries Units services in West Dorset responsibility for which transferred to the Trust with effect from November 2016.

Commissioner-requested services are services which local commissioners believe should continue to be provided locally if any individual provider is at risk of failing financially. Any organisation providing a commissioner-requested service has to continue offering the service unless it can obtain agreement from NHS Improvement and the commissioners to stop. It cannot dispose of relevant assets used to provide the service without NHS Improvement consent and it must pay into a risk pool that will fund services in the event of financial failure.

4.2 Analysis by source	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
NHS - Foundation Trusts	194	167
NHS - Trusts	-	5
NHS - CCGs and NHS England	148,967	143,041
Local Authorities	1,478	1,571
NHS - Other	45	117
Non NHS - Private patients	939	969
Non NHS - Overseas patients	70	49
NHS Injury Scheme	385	340
Non NHS - Other	25	27
Department of Health	-	600
<b>Total</b>	<b>152,103</b>	<b>146,886</b>

NHS Injury Scheme income relating to the 2016/17 financial year is subject to a provision for doubtful debts of 22.94% (2015/16: 22%) to reflect expected rates of collection.

Overseas patient income for the year amounted to £70k (2015/16 £49k). Cash received amounted to £42k (2015/16 £33k) in respect of current and previous years' income. The amounts written off in respect of current and prior years amounted to £nil (2015/16 £1k).

5. Other operating income	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
	Note	
Research and development	933	813
Education and training	5,260	4,699
Received from NHS Charities: Physical assets	7	456
Received from other bodies: Cash donations	370	577
Non-patient care services to other bodies	5,024	4,466
Sustainability and Transformation Fund income	5,317	-
Rental revenue from operating leases	7.2 12	-
Car parking	551	533
Estates recharges	41	30
Staff recharges	398	327
IT recharges	23	24
Pharmacy sales	83	90
Staff accommodation rentals	193	205
Clinical excellence awards	181	161
Catering	604	631
Other income	103	33
<b>Total</b>	<b>19,100</b>	<b>13,045</b>

6. Operating expenses	Note	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
Employee expenses	8.1	106,619	103,065
Employee expenses - Non-executive directors		122	123
Services from NHS Foundation Trusts		3,860	2,619
Services from NHS Trusts		190	165
Services from CCGs and NHS England		466	453
Services from other NHS bodies		55	59
Purchase of healthcare from non NHS bodies		3,406	2,877
Supplies and services - clinical (excluding drug costs)		17,090	16,341
Supplies and services - general		1,697	1,834
Establishment		937	1,132
Research and Development		30	33
Transport (Business travel only)		445	409
Transport (other)		221	186
Premises - Business rates payable to Local Authorities		977	968
Premises - Other		5,926	5,276
Increase/(decrease) in provision for impairment of receivables		9	(11)
Change in provisions discount rate		15	(1)
Inventories written down (net, including drugs)		32	35
Drug costs (non inventory)		325	295
Drug costs inventories consumed		14,376	13,881
Rentals under operating leases - minimum lease payments	7.1	91	99
Depreciation on property, plant and equipment		4,401	5,624
Amortisation on intangible assets		765	784
Net Impairment of property, plant and equipment		(142)	(14)
Net Impairment of intangible assets		126	-
External audit - statutory audit services		41	41
External audit - other assurance services		7	7
Clinical negligence - NHSLA Insurance Scheme		5,814	5,147
Legal fees		82	63
Consultancy costs		364	348
Internal Audit Costs - (not included in employee expenses)		110	49
Training courses and conferences		433	414
Patient travel		5	9
Car parking and security		3	3
Insurance		120	126
Other services		121	94
Losses, ex gratia & special payments		4	4
Other		432	353
<b>Total</b>		<b>169,575</b>	<b>162,890</b>

## 7. Operating leases

## 7.1 As lessee

Payments recognised as an expense	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
-----------------------------------	--	--

Minimum lease payments:

Buildings	47	47
Plant & machinery	-	1
Other	44	51
<b>Total minimum lease payments</b>	<b>91</b>	<b>99</b>

Future minimum lease payments on buildings leases due:	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
---	--	--

Not later than one year	43	47
Between one and five years	-	40
<b>Total</b>	<b>43</b>	<b>87</b>

Future minimum lease payments on other leases due:	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
Not later than one year	3	9
Between one and five years	8	8
<b>Total</b>	<b>11</b>	<b>17</b>

## 7.2 As lessor

Rental recognised as an income	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
--------------------------------	--	--

Minimum lease payments:

Land	12	-
<b>Total minimum lease payments</b>	<b>12</b>	<b>-</b>

Future minimum lease payments on land leases due:	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
--	--	--

Not later than one year	18	-
<b>Total</b>	<b>18</b>	<b>-</b>



## 8. Employee expenses and numbers

8.1 Employee expenses	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
Employee expenses - Staff	104,863	101,415
Employee expenses - Executive directors	993	893
Employee expenses - Research and Development staff	754	688
Employee expenses - Internal Audit Staff - Counter Fraud	-	54
Redundancy	23	8
Early retirements	(14)	7
	<b>106,619</b>	<b>103,065</b>
Salaries and wages	85,406	83,689
Social security costs	7,928	6,236
Employer contributions to NHS Pension scheme	10,150	9,925
Pension cost - other	10	5
Agency and contract staff	3,395	3,306
Termination benefits	100	77
Less: Staff costs capitalised as part of assets	(370)	(173)
<b>Employee benefits expense</b>	<b>106,619</b>	<b>103,065</b>

Salaries and wages include the cost of amounts accrued in respect of holiday earned by employees due to their service, but not taken, as required under IAS 19.

The amount of Employer's pension contributions payable in the year ended 31 March 2017 was £10,160k (2015/16: £9,930k). Of this total, an amount of £848k (2015/16: £833k) was unpaid at the reporting date.

## 8.2 Average number of employees (WTE basis)

	Average for year ended 31 March 2017			Average for year ended 31 March 2016
	Total number	Permanent number	Other number	Total number
Medical and dental	299	294	5	299
Administration and estates	452	452	-	485
Healthcare assistants and other support staff	423	423	-	304
Nursing, midwifery and health visiting staff	625	625	-	627
Scientific, therapeutic and technical staff	241	241	-	245
Healthcare science staff	97	97	-	116
Social care and staff	4	1	3	4
Agency and contract staff	27	-	27	32
Bank staff	132	132	-	130
Other	99	99	-	153
<b>Total</b>	<b>2,399</b>	<b>2,364</b>	<b>35</b>	<b>2,395</b>
Of which: Engaged on capital projects	<b>8</b>	<b>8</b>	<b>-</b>	<b>4</b>

The average number of employees is calculated on the basis of the number of worked hours reported. This means that the reporting of staff numbers and staff costs incurred are on a more consistent basis.



### 8.3 Retirement benefits

#### NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://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:

#### 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.

#### 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 2016. 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.

## 9. Retirements due to ill-health

During 2016/17 there was 1 case (2015/16: 1 case) of early retirement from the Trust agreed on grounds of ill-health. The estimated additional pension liabilities of this ill-health retirement will be £23k (2015/16: £2k). The cost of ill-health retirements is borne by the NHS Business Services Authority – Pensions Division. This information has been supplied by NHS Pensions.

## 10. Salary and pension entitlement of directors and senior managers

### 10.1 Directors Remuneration

	Year ended 31 March 2017 £000	Year ended 31 March 2016 £000
Directors remuneration - Salaries and wages	803	672
Employers pension contributions in respect of directors	87	83
Interim director fees	-	41
	<b>890</b>	<b>796</b>
	<b>Number</b>	<b>Number</b>
The total number of directors to whom retirement benefits were accruing under:		
Defined contribution schemes	1	1
Defined benefit schemes	<b>6</b>	<b>6</b>

Detailed disclosures of the remuneration and pension entitlements of each director are set out on pages 33 to 38 of the Remuneration Report.

### 10.2 Multiple Statement

All NHS Foundation Trusts are required to disclose the relationship between the total remuneration of the highest-paid director of the Trust and the median remuneration of the Trust's workforce. The remuneration of the highest paid director includes salary, performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions or the cash equivalent transfer value of pensions. The median remuneration of the workforce is the total remuneration of the staff member lying in the middle of the linear distribution of the total staff in the Trust, excluding the highest paid director. This is based on an annualised full time equivalent remuneration as at the reporting period date.

The banded remuneration of the highest-paid director in 2016/17 was £155,001 to £160,000 (2015/16: £155,001 to £160,000). This was 5.99 times (2015/16: 6.29 times) the median remuneration of the workforce, which was £26,302 (2015/16: £25,047). The highest paid Director was the Chief Executive.

The median remuneration of the workforce in both 2016/17 and 2015/16 falls within the salary range of a Band 5 position under the Agenda for Change terms and conditions that apply to all non-medical staff. The actual salary of staff within each band is dependent on a number of factors, the most significant being the number of years they have served in that position.

In 2016/17 9 employees received remuneration in excess of the highest paid director (2015/16: 9 employees). Remuneration ranged from £160,000 to £195,000 (2015/16: £158,000 to £276,000). All employees receiving remuneration in excess of the highest paid director were medical consultants.

<b>11. Finance income</b>	<b>Year ended 31 March 2017 £000</b>	<b>Year ended 31 March 2016 £000</b>
Interest on bank accounts	14	13
Interest on loans and receivables	77	64
<b>Total</b>	<b>91</b>	<b>77</b>

Interest on loans and receivables includes £70,000 received in relation to a historic VAT claim.

<b>12. Finance expenses - interest expense</b>	<b>Year ended 31 March 2017 £000</b>	<b>Year ended 31 March 2016 £000</b>
Loans from the Department of Health	97	97
Finance Leases	8	6
<b>Total</b>	<b>105</b>	<b>103</b>

<b>13. Gains/(losses) on disposals</b>	<b>Year ended 31 March 2017 £000</b>	<b>Year ended 31 March 2016 £000</b>
Gains on disposal of other property, plant and equipment	3	62
Losses on disposal of other property, plant and equipment	(33)	(148)
Losses on disposal of intangible assets	(12)	-
<b>Total gains/(losses) on disposal of assets</b>	<b>(42)</b>	<b>(86)</b>

<b>14. Impairment of non-current assets</b>	<b>Year ended 31 March 2017 £000</b>	<b>Year ended 31 March 2016 £000</b>
<b>Impairment</b>		
Unforeseen obsolescence	127	-
Changes in market price*	3,557	503
Reversal of impairments*	(247)	(15)
<b>Total impairments</b>	<b>3,437</b>	<b>488</b>

\* Resulting from the revaluation of land and buildings as at 31 March.

Total impairments have been charged/(credited) to the following lines in the Statement of Comprehensive Income.

	<b>Year ended 31 March 2017 £000</b>	<b>Year ended 31 March 2016 £000</b>
Operating Expenses	(16)	(14)
Revaluation reserve	3,453	502
	<b>3,437</b>	<b>488</b>

15. Intangible assets	Software licences 2016/17 £000	Software licences 2015/16 £000
<b>Cost or valuation at 1 April</b>	6,946	5,842
Additions - purchased	1,705	1,082
Additions - donated	-	22
Disposals	(1,314)	-
<b>Cost or valuation at 31 March</b>	<b>7,337</b>	<b>6,946</b>
<b>Amortisation at 1 April</b>	3,401	2,617
Provided in the year	765	784
Impairments charged to operating expenses	126	-
Disposals	(1,302)	-
<b>Amortisation at 31 March</b>	<b>2,990</b>	<b>3,401</b>
<b>Net book value</b>		
Purchased	4,313	3,490
Donated	34	55
<b>Net book value total at 31 March</b>	<b>4,347</b>	<b>3,545</b>

Software licences have been assigned asset lives of between 5 and 10 years. The total reported includes £1,878k (2016: £884k) of software under construction. This includes £1,549k (2016: £719k) of the Digital Patient Record (DPR) for the delivery of an electronic patient record system.

## 16. Property, plant and equipment

Assets utilised by the Trust under Finance leases arrangements are capitalised as part of property, plant and equipment under IFRS. The net book value of fixed assets held at the balance sheet date that were subject to a finance lease was £506k (2016: £482k).

The Trust's land and buildings were valued by external valuers as at 31 March 2017 on the basis of fair value, as set out in accounting policy note 1.6.2. The valuation was undertaken by Bilfinger GVA.

## DCHFT Annual Report and Accounts 2016/17

### 16.1 Property, plant and equipment, current year

Current year 2016/17	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
<b>Cost or valuation at 1 April 2016</b>	<b>111,384</b>	8,942	64,960	1,915	245	26,054	8,673	595
Additions - purchased	1,827	-	535	-	510	509	262	11
Additions - leased	305	-	-	-	-	-	305	-
Additions - donations of physical assets	7	-	-	-	-	6	-	1
Additions - assets purchased from cash donations/grants	370	-	100	-	270	-	-	-
Impairments charged to operating expenses	(110)	(20)	(90)	-	-	-	-	-
Impairments charged to revaluation reserve	(4,073)	(1,833)	(2,240)	-	-	-	-	-
Reversal of Impairments credited to operating expenses	241	128	25	88	-	-	-	-
Reclassification	-	-	59	-	(237)	-	178	-
Revaluation surpluses	6,193	20	3,924	2,249	-	-	-	-
Disposals	(3,893)	-	-	-	-	(934)	(2,959)	-
<b>Cost or valuation at 31 March 2017</b>	<b>112,251</b>	<b>7,237</b>	<b>67,273</b>	<b>4,252</b>	<b>788</b>	<b>25,635</b>	<b>6,459</b>	<b>607</b>
<b>Depreciation at 1 April 2016</b>	<b>20,628</b>	-	-	-	-	14,199	6,263	166
Provided in the year	4,401	-	1,010	25	-	2,386	954	26
Impairments recognised in operating expenses	(5)	-	(6)	-	-	-	1	-
Impairments recognised in revaluation reserve	(620)	-	(620)	-	-	-	-	-
Reversal of impairments recognised in other operating expenses	(6)	-	(5)	(1)	-	-	-	-
Revaluation surpluses	(403)	-	(379)	(24)	-	-	-	-
Disposals	(3,854)	-	-	-	-	(900)	(2,954)	-
<b>Depreciation at 31 March 2017</b>	<b>20,141</b>	-	-	-	-	<b>15,685</b>	<b>4,264</b>	<b>192</b>
<b>Net book value as at 31 March 2017</b>								
Owned assets	87,602	7,237	65,218	4,252	518	8,397	1,896	84
Finance lease	506	-	-	-	-	232	274	-
Donated assets	4,002	-	2,055	-	270	1,321	25	331
<b>Total at 31 March 2017</b>	<b>92,110</b>	<b>7,237</b>	<b>67,273</b>	<b>4,252</b>	<b>788</b>	<b>9,950</b>	<b>2,195</b>	<b>415</b>

## 16.2 Property, plant and equipment, prior year

Prior year 2015/16	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
<b>Cost or valuation at 1 April 2015</b>	<b>116,051</b>	9,100	65,918	1,915	159	29,927	8,418	614
Additions - purchased	2,216	-	842	-	245	870	259	-
Additions - donations of physical assets	434	-	26	-	-	396	-	12
Additions - assets purchased from cash donations/grants	577	-	-	-	-	577	-	-
Impairments charged to operating	(9)	-	(9)	-	-	-	-	-
Impairments charged to revaluation	(1,334)	(158)	(1,176)	-	-	-	-	-
Reclassification	-	-	159	-	(159)	-	-	-
Revaluation surpluses	(800)	-	(800)	-	-	-	-	-
Disposals	(5,751)	-	-	-	-	(5,716)	(4)	(31)
<b>Cost or valuation at 31 March 2016</b>	<b>111,384</b>	<b>8,942</b>	<b>64,960</b>	<b>1,915</b>	<b>245</b>	<b>26,054</b>	<b>8,673</b>	<b>595</b>
<b>Depreciation at 1 April 2015</b>	<b>22,720</b>	-	-	-	-	17,267	5,281	172
Provided in the year	5,624	-	2,099	35	-	2,479	986	25
Impairments recognised in operating expenses	(8)	-	(8)	-	-	-	-	-
Impairments recognised in revaluation reserve	(832)	-	(812)	(20)	-	-	-	-
Reversal of Impairments recognised in operating expenses	(15)	-	-	(15)	-	-	-	-
Revaluation surpluses	(1,279)	-	(1,279)	-	-	-	-	-
Disposals	(5,582)	-	-	-	-	(5,547)	(4)	(31)
<b>Depreciation at 31 March 2016</b>	<b>20,628</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>14,199</b>	<b>6,263</b>	<b>166</b>
<b>Net book value as at 31 March 2016</b>								
Owned assets	86,773	8,942	63,450	1,915	245	9,831	2,300	90
Finance lease	482	-	-	-	-	419	63	-
Donated assets	3,501	-	1,510	-	-	1,605	47	339
<b>Total at 31 March 2016</b>	<b>90,756</b>	<b>8,942</b>	<b>64,960</b>	<b>1,915</b>	<b>245</b>	<b>11,855</b>	<b>2,410</b>	<b>429</b>

**17. Capital commitments**

Contracted capital commitments at 31 March not otherwise included in these financial statements comprise:

	<b>31 March 2017 £000</b>	31 March 2016 £000
Property, plant and equipment	679	681
Intangible assets	1,294	2,249
<b>Total</b>	<b><u>1,973</u></b>	<b><u>2,930</u></b>

**18. Inventories**

<b>Current year 2016/17</b>	<b>Drugs £000</b>	<b>Consumables £000</b>	<b>Other £000</b>	<b>Total £000</b>
Balance at 1 April	722	2,330	91	<b>3,143</b>
Additions	14,491	5,444	626	<b>20,561</b>
Inventories recognised as an expense in the period	(14,376)	(5,639)	(631)	<b>(20,646)</b>
Write-down of inventories recognised as an expense	(32)	-	-	<b>(32)</b>
<b>Balance at 31 March</b>	<b><u>805</u></b>	<b><u>2,135</u></b>	<b><u>86</u></b>	<b><u>3,026</u></b>
 <b>Prior year 2015/16</b>	 <b>Drugs £000</b>	 <b>Consumables £000</b>	 <b>Other £000</b>	 <b>Total £000</b>
Balance at 1 April	744	2,210	113	3,067
Additions	13,894	5,245	625	19,764
Inventories recognised as an expense in the period	(13,881)	(5,125)	(647)	(19,653)
Write-down of inventories recognised as an expense	(35)	-	-	(35)
<b>Balance at 31 March</b>	<b><u>722</u></b>	<b><u>2,330</u></b>	<b><u>91</u></b>	<b><u>3,143</u></b>

The Trust does not currently operate a complete inventory management control system and is therefore not able to separately evaluate any amount arising, from write-downs or losses, for inventories other than drugs.

**19. Trade and other receivables**

<b>19.1 Trade and other receivables</b>	<b>31 March</b>	<b>31 March</b>
	<b>2017</b>	<b>2016</b>
	<b>£000</b>	<b>£000</b>
<b>Current</b>		
NHS receivables	6,856	2,602
Other receivables with related parties	275	156
Provision for the impaired receivables	(84)	(75)
Prepayments	1,448	1,472
Accrued income	289	374
Interest receivable	1	1
PDC dividend receivable	-	19
VAT receivables	352	281
Other receivables	604	816
<b>Total</b>	<b>9,741</b>	<b>5,646</b>
<b>Non-current</b>		
Prepayments	125	95
Accrued income	182	146
<b>Total</b>	<b>307</b>	<b>241</b>
<b>Grand Total</b>	<b>10,048</b>	<b>5,887</b>

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by central government to buy NHS patient care services, no credit scoring of them is considered necessary.

**19.2 Receivables past their due date but not impaired**

	<b>31 March</b>	<b>31 March</b>
	<b>2017</b>	<b>2016</b>
	<b>£000</b>	<b>£000</b>
By one to two months	416	46
By two to three months	100	202
By three to six months	160	103
By more than six months	468	349
<b>Total</b>	<b>1,144</b>	<b>700</b>

**19.3 Receivables past their due date and impaired**

	<b>31 March</b>	<b>31 March</b>
	<b>2017</b>	<b>2016</b>
	<b>£000</b>	<b>£000</b>
By up to one month	3	-
By one to two months	3	2
By two to three months	7	3
By three to six months	28	75
By more than six months	407	380
<b>Total</b>	<b>448</b>	<b>460</b>



#### 19.4 Provision for impairment of receivables

	31 March 2017 £000	31 March 2016 £000
Balance at 1 April	75	86
Increase/(decrease) in receivables impaired	9	(11)
<b>Balance at 31 March</b>	<b>84</b>	<b>75</b>

#### 20. Cash and cash equivalents

	31 March 2017 £000	31 March 2016 £000
Balance at 1 April	4,018	8,076
Net change in year	409	(4,058)
<b>Balance at 31 March</b>	<b>4,427</b>	<b>4,018</b>
<b>Made up of</b>		
Commercial banks and cash in hand	5	5
Cash with Government Banking Service	4,422	4,013
<b>Cash and cash equivalents</b>	<b>4,427</b>	<b>4,018</b>

#### 21. Trade and other payables

	31 March 2017 £000	31 March 2016 £000
<b>Current</b>		
NHS payables	1,923	258
Amounts due to other parties*	1,580	1,701
Trade payables - capital	1,190	1,010
Other payables	5,072	3,520
Other taxes payable	2,191	1,944
Accruals	2,809	1,871
PDC payable	43	-
<b>Total</b>	<b>14,808</b>	<b>10,304</b>

\* Amounts due to other parties includes outstanding pension contributions of £1,424k (2016 £1,397k).

#### 22. Borrowings

	Current	
	31 March 2017 £000	31 March 2016 £000
Obligations under finance leases	169	181
<b>Total</b>	<b>169</b>	<b>181</b>
	Non-current	
	31 March 2017 £000	31 March 2016 £000
Loans from Department of Health	4,600	4,600
Obligations under finance leases	289	181
<b>Total</b>	<b>4,889</b>	<b>4,781</b>

The Trust drew down a loan from the Department of Health against the receipt of future asset sales. This loan is repayable by 15<sup>th</sup> March 2021.

## 23. Provisions

	<b>Current</b>	
	<b>31 March</b>	<b>31 March</b>
	<b>2017</b>	<b>2016</b>
	<b>£000</b>	<b>£000</b>
Pensions early departure costs	54	57
Other legal claims	34	38
<b>Total</b>	<b>88</b>	<b>95</b>

	<b>Non-current</b>	
	<b>31 March</b>	<b>31 March</b>
	<b>2017</b>	<b>2016</b>
	<b>£000</b>	<b>£000</b>
Pensions early departure costs	387	437
<b>Total</b>	<b>387</b>	<b>437</b>

<b>23.1 Provisions movement</b>	<b>Total</b>	<b>Pensions early departure costs</b>	<b>Legal and other claims</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>At 1 April 2016</b>	<b>532</b>	<b>494</b>	<b>38</b>
Change in discount rate	15	15	-
Arising during the year	30	4	26
Utilised during the year - accruals	(14)	(14)	-
Utilised during the year - cash	(58)	(41)	(17)
Reversed unused	(31)	(18)	(13)
Unwinding of discount	1	1	-
<b>At 31 March 2017</b>	<b>475</b>	<b>441</b>	<b>34</b>

### Expected timing of cash flows:

Within one year	88	54	34
Between one and five years	193	193	-
After 5 years	194	194	-
<b>Total</b>	<b>475</b>	<b>441</b>	<b>34</b>

Provisions that are not expected to become due for several years are shown at a reduced value to take account of inflation. The unwinding of discounts relates to the increase in the value of provisions as their settlement date gets nearer.

Provisions shown under the heading 'Pensions early departure costs' have been calculated using figures provided by the NHS Pension Agency. They assume certain life expectancies. Provisions shown under the heading 'Legal claims' relate to public and employer liability claims. The liability claims amounts have been calculated using information provided by the NHS Litigation Authority and are based on the best information available at the balance sheet date

## 23.2 Clinical negligence liabilities

	<b>31 March</b>	<b>31 March</b>
	<b>2017</b>	<b>2016</b>
	<b>£000</b>	<b>£000</b>
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of the Trust	71,333	51,338

24. Other liabilities	31 March 2017 £000	31 March 2016 £000
Deferred income - goods and services	961	916
<b>Total</b>	<b>961</b>	<b>916</b>

25. Finance lease obligations	Minimum lease payments		Present value of minimum lease payments	
	31 March 2017 £'000	31 March 2016 £'000	31 March 2017 £'000	31 March 2016 £'000
<b>Gross lease liabilities</b>	<b>483</b>	<b>364</b>	<b>459</b>	<b>354</b>
<b>of which liabilities are due</b>				
not later than one year	180	183	176	177
later than one year and not later than five years	303	170	283	166
later than five years	-	11	-	11
Finance charges allocated to future periods	(25)	(2)	(25)	(2)
<b>Net lease liabilities</b>	<b>458</b>	<b>362</b>	<b>434</b>	<b>352</b>
<b>of which liabilities are due</b>				
not later than one year	169	181	164	175
later than one year and not later than five years	289	170	270	166
later than five years	-	11	-	11
	<b>458</b>	<b>362</b>	<b>434</b>	<b>352</b>

All finance lease obligations disclosed above relate to plant and machinery.

## 26. Contingencies

Contingent liabilities	31 March 2017 £000	31 March 2016 £000
Risk pooling*	24	10
Early retirement	3	20
Injury benefits	19	22
<b>Total</b>	<b>46</b>	<b>52</b>

\* Risk pooling is in respect of employer and public liability incidents for which claims have been made against the Trust. The contingent liabilities have been calculated using information provided by the NHS Litigation Authority. Provisions relating to these cases are included in Note 23.

## 27. Financial instruments

### 27.1 Financial assets

	31 March 2017 £000	31 March 2016 £000
<b>Loans and receivables</b>		
Trade and other receivables	8,123	4,020
Cash and cash equivalents at bank and in hand	4,427	4,018
<b>Total at 31 March</b>	<b>12,550</b>	<b>8,038</b>

The financial assets consist of the financial element of trade and other receivables (Note 19.1) and cash and cash equivalents at bank and in hand (Note 20).

### 27.2 Financial liabilities

	31 March 2017 £000	31 March 2016 £000
Borrowing excluding finance lease and PFI contract	4,600	4,600
Obligations under finance lease	458	362
Trade and other payables	10,749	6,583
Provisions under contract	475	532
<b>Total at 31 March</b>	<b>16,282</b>	<b>12,077</b>

#### Maturity of

In one year or less	11,006	6,859
In more than one year but not more than two years	133	159
In more than two years but not more than five years	4,949	218
In more than five years	194	4,841
	<b>16,282</b>	<b>12,077</b>

The financial liabilities consist of the financial element of trade and other payables (Note 21), plus current and non-current borrowings (Note 22) and provisions (Note 23.1) excluding legal costs.

### 27.3 Fair value of financial assets

	Book Value £000	Fair Value £000
Non-current trade and other receivables excluding non financial assets	182	182
<b>Total at 31 March 2017</b>	<b>182</b>	<b>182</b>

### 27.4 Fair value of financial liabilities

	Book Value £000	Fair Value £000
Provisions under contract	387	387
Loans	4,600	4,600
Other	289	289
<b>Total at 31 March 2017</b>	<b>5,276</b>	<b>5,276</b>

## 27.5 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions and Policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

### 27.5.1 Currency risk

The Trust is a UK based organisation with no overseas operations. The vast majority of its income, expenses, assets and liabilities are denominated in sterling, and therefore it has low exposure to currency risk.

### 27.5.2 Interest rate risk

The Trust's exposure to interest rate risk is limited to the rate of interest it earns on short-term cash deposits placed with the National Loans Fund and its cash balances with the Government Banking Service. All of the borrowings of the Trust are at fixed rates of interest.

The Trust earned interest of £21,000 (at an average rate of approximately 0.2%) during 2016/17. An increase in interest rates of 0.5% would increase interest earned by approximately £53,000.

### 27.5.3 Credit risk

The majority of the Trust's trade and other receivables are due from other NHS bodies that are funded by central government. As a result, the Trust has a low credit risk profile. Exposures as at 31 March are disclosed in the Trade and other receivables note.

The Trust has a credit control policy and actively pursues unpaid debts, utilising the services of a debt collection agency for certain older debts. The Trust does not enter into derivative contracts.

### 27.5.4 Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from internally generated funds, or from facilities made available from Government under an agreed borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has a deficit £1.1m in the current financial year and has a cash balance of £4.4m. Therefore there is minimal risk to payables.

## 28. Events after the reporting period

There have been no significant post balance sheet events requiring disclosure.

## 29. Related party transactions

Dorset County Hospital NHS Foundation Trust is an independent public benefit corporation as authorised by NHS Improvement in their Terms of Authorisation.

None of the Trust's Directors, senior managers, or parties deemed to be related to them, has undertaken any material transactions with Dorset County Hospital NHS Foundation Trust.

The Department of Health is regarded as the ultimate parent of the Trust. During the year the Foundation Trust has had a significant number of transactions with entities for which the Department of Health is regarded as the ultimate parent.

Central and Local Government and NHS entities, with which the Foundation Trust had transaction totals exceeding £500,000 for the year, are listed in the following table.

	<b>Income</b>	<b>Expenditure</b>	<b>Receivables</b>	<b>Payables</b>
	<b>in year to 31</b>	<b>in year to 31</b>	<b>at 31 March</b>	<b>at 31 March</b>
	<b>March 2017</b>	<b>March 2017</b>	<b>2017</b>	<b>2017</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Department of Health	-	-	-	4,604
Dorset County Council	1,555	617	201	371
Dorset Healthcare NHS Foundation Trust	1,310	2,730	29	1,263
Health Education England	5,267	11	14	-
HM Revenue and Customs - Tax & NI	-	7,944	-	2,191
NHS Blood and Transplant	4	648	-	7
NHS Dorset Clinical Commissioning Group	114,590	186	2,613	645
NHS England - Core	5,317	280	2,135	64
NHS England - Wessex Local Office	3,338	-	6	54
NHS England - South Central Local Office	900	-	25	-
NHS England - Wessex Commissioning Hub	25,839	-	919	-
NHS Litigation Authority	-	5,920	-	-
NHS Pension Scheme	-	10,150	-	1,434
NHS Somerset Clinical Commissioning Group	2,135	-	-	145
Poole Hospital NHS Foundation Trust	1,172	1,115	401	169
University Hospital Southampton NHS Foundation Trust	819	277	14	60
Somerset Partnership NHS Foundation Trust	552	-	72	-

The payables included above in respect of HM Revenue and Customs and NHS Pension Scheme include both employee and employer contributions. The expenditure figures for these organisations are only in respect of employer contributions.

The Trust receives revenue payments and contributions to the cost of non-current assets from the Dorset County Hospital NHS Foundation Trust Charitable Fund, of which the Foundation Trust is the corporate trustee.

Transactions with Dorset County Hospital	<b>31 March</b>	31 March
NHS Foundation Trust Charitable Fund:	<b>2017</b>	2016
	<b>£000</b>	£000
Contributions from the Charity to non-current assets	277	456
Administration costs charged to the Charity	22	22

### **30. Third Party Assets**

The Trust holds cash and cash equivalents which relate to monies held on behalf of patients. These amounts have been excluded from the cash and cash equivalents figure reported in the accounts.

	<b>31 March</b>	31 March
	<b>2017</b>	2016
	<b>£000</b>	£000
Monies held on behalf of patients	<u>1</u>	<u>2</u>

### **31. Losses and special payments**

The total costs included in this note are on a cash basis and may not reconcile to the amounts in the notes to the accounts, which are prepared on an accruals basis.

	<b>Number of cases</b>		<b>Total value of cases</b>	
	<b>31 March</b>	31 March	<b>31 March</b>	31 March
	<b>2017</b>	2016	<b>2017</b>	2016
	<b>Number</b>	Number	<b>£'000</b>	£'000
Losses of cash due to:				
overpayment of salaries	-	5	-	2
Bad debts and claims abandoned in relation to:				
private patients	1	-	-	-
overseas visitors	-	1	-	1
other	1	12	-	1
Damage to buildings and property due to:				
stores losses	1	1	32	35
Ex-gratia payments in respect of:				
loss of personal effects	19	10	4	2
other	4	1	1	-
	<u>26</u>	<u>30</u>	<u>37</u>	<u>41</u>

### **32. Limitation on auditor's liability**

The limitation on the Trust's auditor's liability is £0.5million (2015/16: £0.5million).

### 33. Pooled Budget – Equipment for Living Partnership

The Trust, via Dorset CCG, contributes towards a pooled budget arrangement which started on the 1<sup>st</sup> April 2015. This is hosted by Bournemouth Borough Council to provide equipment for Living Partnership. This replaced the Integrated Equipment Service hosted by Dorset County Council which ceased on the 31<sup>st</sup> March 2015.

Payments are included in note 6 – Operating expenses under heading Services from CCGs and NHS England. The Trust contributed £185k in 2016/17 (£185k 2015/16). This forms part of the Dorset CCG total included in the table below.

The below disclosure is based on month 12 information provided by Bournemouth Borough Council and it should be noted that these figures are un-audited.

	<b>Year ended 31 March 2017 £000</b>	<b>Year ended 31 March 2016 £000</b>
<b>Funding</b>		
Bournemouth Borough Council	637	552
Borough of Poole	592	552
Dorset County Council	1,296	1,439
Dorset CCG	5,058	5,058
Partner Contributions (excluding management costs)	<u>7,583</u>	<u>7,601</u>
Partner Allocation: Local Authority	122	(69)
Partner Allocation: CCG	<u>247</u>	<u>(139)</u>
<b>Total Funding</b>	<b><u>7,952</u></b>	<b><u>7,393</u></b>
<b>Expenditure</b>		
Integrated Community Equipment Store		
Actual Spend to March	<u>(7,952)</u>	<u>(7,393)</u>
<b>Total Expenditure</b>	<b><u>(7,952)</u></b>	<b><u>(7,393)</u></b>
<b>Total Surplus/(Deficit) at 31 March</b>	<b><u>-</u></b>	<b><u>-</u></b>





