Poole Hospital NHS
NHS Foundation Trust

# Poole Hospital NHS Foundation Trust

# Annual report and accounts 2011/12

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## Presented to Parliament pursuant to Schedule 7, Paragraph 25(4) of the National Health Service Act 2006.

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# Welcome

Welcome to Poole Hospital NHS Foundation Trust's annual report and accounts for the financial year 2011/12. We hope you find it of interest as we retrace the events and successes of the past 12 months. This report is just one of the ways in which we demonstrate our accountability to those we serve. We are also held to account by our council of governors, and we are most grateful to them for their time and commitment. They effectively achieve a balance between support and scrutiny which ensures that we are always seeking to improve.

Perhaps the most significant event of 2011/12 was our release from 'significant breach' of our foundation trust authorisation, which we were placed in by our regulator, Monitor, in July 2010.

Following Monitor's decision, which came in response to disappointing financial performance in 2009/10, a new chief executive, executive and non-executive directors were appointed and have been instrumental in leading our transformation back to financial health. Staff working at Poole Hospital at all levels and areas have made a significant contribution to this improved position, delivering cost savings in this financial year alone of around £10m, and their efforts are noted with sincere thanks.

Returning to a financially stable position is not the end of the story, however. Nationally, the NHS today faces a number of serious challenges, not least of which are providing safe and sustainable clinical services and recruiting a high quality clinical and non-clinical workforce to deliver and support these services.

That is why in late 2011, our board of directors, and that of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, made independent decisions to move to a formal phase in an exploration of merger between the two organisations.

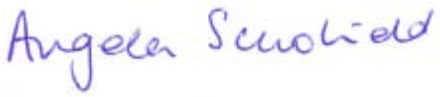
We believe that merger gives us the best opportunity to continue to provide, and develop further, the excellent clinical services for which both hospitals are highly regarded. There will also be significant benefits for our staff through improvements to career opportunities and potential to progress. You can read more about these plans elsewhere in this report.

As we write, the Health and Social Care Bill has completed its journey through both Houses of Parliament, which will add further changes to the landscape in which we operate. The subtleties of this Act will no doubt become clearer in time.

Elsewhere, we were pleased to note the outcomes of various independent reports and patient surveys, covering areas ranging from our outpatients services to hygiene standards. In 2011/12 we became the only acute trust in the country to enjoy full practice development unit status across our entire range of services – independent endorsement our services are progressive and patient focused. You can read more about other notable achievements throughout this report.

Finally, one of the last events of this financial year, the Poole Hospital Awards, were held in late March. This was a wonderfully uplifting occasion, in which exceptional staff, volunteers and fundraisers were honoured, and which served to remind us all why we work for such a great institution as the NHS and why it is so highly regarded by our communities. Opening the nomination process to our patients and the public gave us a unique insight into how those who work at or support Poole Hospital are seen by those we serve. We are very grateful for all who took the time to nominate our outstanding individuals and teams.

Thank you for your interest in Poole Hospital, and we sincerely hope you enjoy finding out more about us and our work in this annual report.



**Angela Schofield**
Chairman

**Chris Bown**
Chief executive

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# Directors' report

**About Foundation Trusts**

Poole Hospital became an NHS Foundation Trust on 1 November 2007 under the National Health Service Act 2006.

NHS Foundation Trusts provide healthcare according to core NHS principles: free care, based on need and not the ability to pay. They are set up as independent, not-for-profit, public benefit corporations and are regulated by Monitor.

Foundation Trusts have greater freedom to develop services in the way that suits local communities and staff. They can decide how to spend their money, borrow capital and generate income, re-invest any surplus cash on developing new services and also own their assets. Foundation Trust boards of directors are held to account by the council of governors who represent the local community through a membership base made up of local people from the trust's catchment area and staff. Anyone who is over the age of 12 and resides in Dorset may apply to be a public member of Poole Hospital NHS Foundation Trust. Staff are automatically members unless they choose to opt out.

As a Foundation Trust, Poole Hospital is run by a board of directors, made up of non-executive and executive directors. The board of directors give strategic leadership to the Trust and develop its direction and culture whilst ensuring it complies with its terms of authorisation.

The board of directors works closely with senior clinical and non-clinical managers and with the council of governors. The council is made of 14 public and four staff governors, who are democratically elected by members of the foundation trust. There are also six appointed governors from our major partnership organisations. The council of governors' responsibilities include representing the interests of our members, the appointment and removal of the chairman and non-executive directors, influencing the plans and priorities of the trust and monitoring the performance of the Trust against its strategic direction and targets.

The chairman chairs both the board of directors and the council of governors.

Full details of the board of directors and council of governors are contained in separate sections of the annual report.

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## About Poole Hospital NHS Foundation Trust

Poole Hospital NHS Foundation Trust is a 623-bed acute general hospital, predominantly serving the 272,000 people living in Poole, east Dorset and Purbeck.

Poole Hospital is the trauma unit for east Dorset, with a 24-hour major accident and emergency department. We also provide a broad range of district hospital care and a number of core services - ear, nose & throat, child health and maternity - for a wider catchment area, including Bournemouth and Christchurch. The hospital also provides specialist county-wide services, such as oral surgery, neurology, and cancer care. These specialist services increase the number of people we serve to more than 700,000.

The Trust operates from three sites – Poole Hospital, St Mary's Maternity Hospital and Forest Holme, our palliative care unit. Our services are regularly inspected and assessed by statutory bodies, including the Foundation Trust regulator Monitor, having particular regard to their quality governance framework. More information on this can be found in the quality report section of this document.

In 2011/12, Poole Hospital employed more than 3,000 whole-time equivalent (WTE) staff and some 300 volunteers who work across the hospital to provide a wide range of invaluable assistance and support to staff and patients.

Our annual turnover for the financial year was almost £196m.

In this time, we gave care to:

- 46,534 inpatients, including maternity
- 23,680 day patients
- 67,148 new outpatients
- 118,635 follow-up outpatients
- 55,288 patients attending our emergency department
- More than 4,600 babies delivered

Poole Hospital has a unique philosophy that underpins the care and service our patients and their families receive. The Poole Approach sets out to ensure that at all times, we provide friendly, professional, patient-centred care with dignity and respect for all, by:

- listening to our staff, patients and the public
- giving information that is relevant and accessible
- safeguarding patient privacy, confidentiality and choice
- welcoming and involving families, carers and friends to participate in care
- treating each other with respect and consideration
- valuing and benefiting from diversity in beliefs, cultures and abilities
- continually improving the quality of our services by learning from what we do
- taking responsibility and being accountable for our own actions
- expecting staff and patients to take their share of responsibility for their own health
- working with and supporting all organisations that are committed to promoting the health of local people.

### Statement of directors' responsibilities

The directors are required under the National Health Service Act 2006 to prepare financial statements for each financial year. The Secretary of State, with the approval of the Treasury, directs that these financial statements give a true and fair view of the state of affairs of the NHS foundation trust and of the income and expenditure of the NHS foundation trust for that period. In preparing those financial statements, the directors are required to: apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury; make judgements and estimates which are reasonable and prudent; and state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the financial statements.

# Performance

Highlights

- Delivery of all key targets for access to emergency and cancer care
- Reduction in healthcare associated infections
- Single sex accommodation standard achieved
- Reduction in emergency re-admissions
- Improvements against a range of 50 service quality indicators
- Improved clinical care in key areas such as mortality, infection prevention and prevention of pressure ulcers. In each of these areas the Trust is performing significantly above the national average
- Achievement of practice development unit status for the whole of the Trust - the only English hospital Trust to do so
- ‘Excellent’ National Patient Safety Agency ratings for hygiene and patient privacy

### Performance standards

In 2011/2012, the Trust delivered both continued financial recovery as well as strong performance against all key operational, quality and clinical standards. This culminated in the Trust being released from significant breach by our regulator, Monitor, in January 2012 and an improved ‘amber/green’ governance rating by the end of the financial year.

Staff at all levels and across all disciplines are to be commended for their hard work and determination in delivering continued high quality services in a period of challenging financial constraints.

Significant work was carried out throughout the year to strengthen performance against the key targets including improvement work in the areas of accident and emergency, trauma, cancer and stroke services. The 18 week referral to treatment standard was achieved in 11 of the 12 months.

A major achievement has been the reduction in bed days lost due to delayed transfers of care through both focussed work within the Trust as well as effective partnership working with our primary, community and social care colleagues. The net result of this work is a reduction of 38 per cent in lost bed days and the impact has been experienced directly by patients in terms of reaching their appropriate onward care destination in a timelier manner.

A further significant work programme has been to continue to focus on reducing the overall length of stay for our patients by improving our bed management and operational flow processes under the banner of right patient, right bed, first time. This programme focuses on reducing delays in patient pathways, reducing the number of patient moves and those who ‘outlie’ from their specialty ward.

Another way we are addressing length of stay is through the development of seven day services to support the progress of care for all our patients over an extended period, with both therapy and pharmacy services establishing in 2011/2012 an extended working model to provide cover on Saturdays and Sundays (see the RACE unit case study, overleaf).

There is further work to do in this area, which is built into the programme for 2012/2013.

Elsewhere, numerous examples of how we are improving the experience of our patients can be found in 2011/12, including the continued development of the Rapid Access Consultant Evaluation (RACE) unit, the appointment of acute physicians working on our acute assessment unit (Ansty), the development of the medical investigations unit (MIU) and the productive operating theatre (TPOT) project, with a wider theatre improvement project commencing recently with a focus on the emergency surgery pathway, under the banner ‘the good theatre’.

**Service improvement – case study**

## National acclaim for innovative unit

Poole Hospital's Rapid Access Consultant Evaluation (RACE) unit was highlighted in a major report in 2011.

The Dr Foster Hospital Guide, published in November, featured the work of the unit to support faster and more senior intervention in acutely ill elderly patients

Consultant opinion is available seven days a week, leading to faster initiation of treatment plans and reductions in the length of time patients spend in hospital.

Clinicians are supported by comprehensive multidisciplinary teams to deliver these treatment plans.

The results have been dramatic – the average length of stay for elderly patients at Poole Hospital has reduced from 14 days to just eight, while half of all patients are assessed and safely discharged with comprehensive care plan in 48 hours

Dr Matt Thomas, consultant geriatrician, helped establish the unit with colleagues.

"We are delighted that the RACE unit was highlighted by Dr Foster after a successful 18 months," he said.

"The success is due to the availability of senior clinical decision-making at an early stage of the patient's time in hospital; comprehensive assessment by a full multidisciplinary team: doctors, nurses, therapists, pharmacists and social services all working closely together, not held back by professional boundaries; and most of all, an attitude that home is the best place for a patient to recover, whenever possible."

The unit works closely with intermediate and GP services to ensure successful discharge. The ward sister follows up the frailer patients by telephone the day after they have gone home, to check that they are safe and well supported, and help to relieve any anxieties.

## Service improvement

To deliver the work associated with strengthening performance against key targets and cost improvements, the Trust has embarked on a Lean training programme. Lean is an approach to identifying and removing inefficiencies and waste in systems, and has been widely adopted in healthcare. To date more than 500 staff have attended an awareness session, while over 60 staff have undertaken a four day training programme on accelerated Lean skills. These programmes have provided tools and techniques for staff at ground level and managers across all disciplines to look differently at how we provide services. This is enabling them to design and implement improvement plans to take out waste and repeat work from the way we deliver our services to patients, with a dual priority on improving the patient experience and reducing cost.

To support both service improvement and cost reduction the Trust reorganised the project management office (PMO) during 2011 bringing together a number of highly skilled individuals from both NHS and non NHS environments to support clinical teams and departments by highlighting cost saving opportunities and support those teams and departments to deliver ideas generated within their own area. To reflect this new skill mix, the PMO is now known as the service transformation team.

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## Quality standards

Our continued commitment to quality has been further underlined in 2011/2012 by our performance in several national surveys. Patients rated our services in the top 20 per cent in England for outpatient care, while we received positive endorsement of our inpatient care in the national inpatient survey.

The continued work of the clinical advisory group (CAG) has provided a robust clinical check across the organisation to ensure that quality and safety remain top priorities. The CAG is made up of clinicians from a range of disciplines across the Trust and meets regularly to review a wide range of quality indicators and highlight risks where they may be anticipated, together with corrective action where appropriate.

The quality section of this report highlights a number of initiatives that are deserving of recognition, particularly in the context of a significant cost reduction and turnaround period that has progressed over the last two years resulting in the current position.

In particular, The Human Touch campaign and the voluntary mealtime companion initiative are to be commended - both have been initiated and driven by staff while sponsored and endorsed at executive director level.

The establishment of the Harbourside Gynaecology Centre and the innovative refurbishment of some elderly care wards have also delivered further significant quality improvements.

**Highlight of the year**

## Quality of care and short waits rated highly by patients

The standard of care in Poole Hospital's outpatient clinics has been rated amongst the best in the country in a survey carried out by the Care Quality Commission.

Patients placed the hospital in the top 20 per cent of trusts when asked to rate the overall care they received, and rated the hospital particularly highly in questions about their consultation with a doctor and their appointment overall.

The hospital was also one of the best performing on waiting times, ranking in the top 20 per cent in questions concerning how long patients were told they would have to wait, and how long they waited after the stated appointment time.

The latest Outpatients Department Survey was carried out by the Care Quality Commission in 2011. 72,000 patients across 163 trusts answered questions on topics including waiting times, hospital environment, tests and treatment, and aspects of their appointment itself. 535 patients at Poole Hospital took part in the survey.

Poole Hospital ranked as one of the best performing trusts nationally in over half the questions reported in the survey.

**Highlight of the year**

## New integrated gynaecology centre opens

MP for mid-Dorset and North Poole, Annette Brook, helped us to mark a new chapter in the provision of high quality women's health services at Poole Hospital when she officially opened the Harbourside Gynaecology Centre in late 2011.

For the first time, all Poole Hospital's women's health outpatient services have been brought together to create a comprehensive range of treatments in a single location.

Robert Syms, MP for Poole, also attended to show his support for the improvements made.

The new centre offers cutting edge and traditional treatments for a range of women's health problems in a relaxed and calming environment, complete with breathtaking harbour views.

Until the centre opened, the individual services, including the emergency assessment and early pregnancy units, were found in a range of locations around the main hospital, as well as in St Mary's Gynaecology Unit, formerly part of the maternity unit in St Mary's Road.

Now the modern and bright centre brings all these services together in one place to provide a range of high quality consultant and specialist nurse-led clinics and diagnostic services. The centre also offers specialist treatments that are found in just a handful of other hospitals in the south of England, including those for complex menopausal problems.

Mr Tim Hillard, consultant gynaecologist and clinical lead for gynaecology, said: "This is a wonderful development that will improve the experience for all those women attending our Women's Health department for whatever reason."

Marian Seddon, matron for surgical services, said patients and staff alike have appreciated their new environment: "We've had so many positive comments from those who have used the centre since we opened.

"Coming into hospital can be a stressful time for anyone, but the welcoming environment creates a positive atmosphere – women know as soon as they walk through our doors that we are 100 per cent dedicated to providing friendly professional care."

**Highlight of the year**

## Trust removed from ‘significant breach’

Poole Hospital was released from ‘significant breach’ of its foundation trust authorisation by the regulator, Monitor, in 2011/12.

Monitor announced the step in January in recognition of ‘substantial improvements’ to the Trust’s governance and financial arrangements.

The Trust was placed in ‘significant breach’ in July 2010 following disappointing financial performance in 2009/10.

Since this time, new executive and non-executive directors, including chief executive and chairman, have been appointed. Progress has been made in a range of areas, with the Trust anticipating a small financial surplus this year.

The regulator reached its conclusion following a series of regular meetings with the Trust’s senior management over the past 18 months.

Chris Bown, chief executive of Poole Hospital NHS Foundation Trust, welcomed the announcement.

"I am extremely pleased that the enormous contribution that our staff have made in bringing the Trust back into financial health has been recognised,” he said.

"The position we find ourselves in today means we can move forward and meet the real challenges we, and the wider NHS, faces in a far stronger position.

“It is to the enormous credit of all staff that in meeting these challenges, the care our patients receive - and that Poole Hospital rightly enjoys an enviable reputation for - remained a key priority.”

**Highlight of the year**

## Golden Rules to better patient care

December 2011 saw the launch of a new initiative to help us to improve still further the experience our patients have in hospital.

We know that at Poole Hospital the vast majority of our patients enjoy a good patient experience and benefit from excellent clinical care. The Golden Rules, part of the Human Touch campaign, seeks to ensure staff follow some simple steps that will ensure we get it right for every patient, every time.

The Human Touch awareness campaign comes after a recent flurry of media coverage based on official reports detailing 'failing standards' in the NHS an ability for some hospitals to 'simply get the basics right'. While Poole Hospital was not the subject of any of these reports, the coverage serves as a sharp reminder of what can happen without proper focus on our patients.

Dr Prem Fade, clinical director for the department for medicine for the elderly, explains more: "Report after report has shown the NHS is not always giving patients and their families the care and support they deserve.

"While Poole Hospital performs well in patient surveys and external reviews this is not a time to be complacent - patients should be at the centre of our vision.

**The Golden Rules**

*Never walk by any patient who needs help or is in distress without giving or seeking help. On every contact with every patient ask, observe, check, and follow the Golden Rules:*

**G**reet the patient and find out how they are feeling
**O**bserve the patient - do they look comfortable, do they have adequate pain relief?
**L**isten to the patient and their relatives, and address their wishes and concerns.
**D**rink - always ensure the patient can reach a drink and the call bell before you leave
**E**xplain what you're doing and ensure the patient understands why you're doing it
**N**ever walk though closed curtains without asking permission first

**R**espect for all - regardless of race, religion, gender, sexual preference or ability.
**U**nderstand how your behaviour, language or attitude may seem to patients or colleagues
**L**ook out for problems and take ownership – don't assume someone else will
**E**mpathise with patients and colleagues – what is it like to be in their shoes?
**S**hare good practice so that everyone can benefit

**Highlight of the year**

## Hospital continues to deliver for patients

Patient areas at Poole Hospital and the privacy and dignity afforded to patients are rated as excellent, according to a new report released this week.

The annual Patient Environment Action Team (PEAT) report evaluates the Trust against a series of criteria in three areas – the environment, privacy and dignity, and food.

The survey found that the patient environment, including cleanliness, lighting, furnishing, car parking and signage, is excellent (awarded five marks out of a possible five), while it also awarded full marks to how the Trust respects the privacy and dignity of patients, looking at areas including the confidentiality of patient information, visiting hours, the assistance available with personal care and the provision of faith services.

The overall award for food, including choice, availability, nutrition, quantity and presentation, was found to be good (four out of five).

Poole Hospital NHS Foundation Trust continues to perform strongly in all three areas, said Martin Smits, director of nursing and patient services, following excellent or good ratings in all three categories in the past three years.

“This is yet another vote of confidence in the activities and services the Trust undertakes as part of offering an all-round great patient experience,” he said.

“We know that patients want high quality care, but they also want and rightly expect this to be given in first rate environments in which their needs, from admission to discharge, are met.

“Whilst pleased with this year’s evaluation we’re not complacent, and we continually look for ways in which we can improve still further.”

PEAT assessments are carried out by hospital staff including nurses, matrons and doctors, as well as patients, their representatives and members of the public. Poole Hospital also chose to use an independent assessor to support this year’s survey.

**Highlight of the year**

## Supporting our patients at mealtimes

Can you spare a few minutes regularly to help support our patients at mealtimes?

If so, Debbie Reeves, our nutrition nurse specialist, wants to hear from you.

The volunteer mealtime companions scheme launched in 2011/12 and seeks to offer help to those patients who may require extra support at mealtimes.

This could be helping to deliver a meal, removing lids, arranging cutlery, feeding a patient or simply providing friendly encouragement to eat or drink. You will not be expected to feed a patient with any swallowing problems.

“Take up from the public has been really good and we’re always keen to hear from more prospective volunteers,” said Debbie.

“Our current volunteers have told me they find the role really rewarding.

“Anyone can volunteer and I would encourage interest from those who can make a regular commitment, from every week to just once a month, to contact me.”

The importance of nutrition in patient care has taken on new focus in recent years, and is the subject of reports from bodies including the Care Quality Commission, Age UK, and others.

Research shows that receiving appropriate nutrition and hydration in hospital can lead to quicker recovery and a better patient experience.

While ward staff already offer this support, volunteers will allow even more one-to-one support and encouragement to provide an enhanced experience in addition to that provided by our nursing teams.

Mealtime companions are trained and supported, and should make an ongoing commitment to the role, for as much or as little time as they want to, on a regular basis.

Participants will benefit too - from a ‘feel good’ factor to improved self-esteem, pride and compassion – and can even make new friends.

If you are interested in becoming a mealtime companion, contact Debbie via the hospital switchboard on (01202) 665511, or email debbie.reeves@poole.nhs.uk

**Highlight of the year**

## Coveted accreditation awarded

Poole Hospital became the only acute Trust in the country to receive coveted independent accreditation for its entire range of clinical services in 2011/12.

Practice Development Unit (PDU) status is awarded to health services found to be progressive, patient-centred and high quality following a rigorous assessment process.

Surgery and trauma, outpatients and oncology and palliative care received their accreditation in late 2011, joining the children's unit, older people's medicine, acute medicine and emergency care which already held PDU status.

The vote of confidence has supported, and will continue to deliver, even better patient care, said Yvonne Jeffrey, assistant director of nursing (practice development).

"The award of this status throughout the Trust is a ringing endorsement of how we continually evolve and challenge services, and involve our patients, to provide the best healthcare possible.

"I'd like to congratulate all members of staff working across the hospital for their commitment and dedication in securing PDU accreditation. It is not easy to achieve, and the fact the entire hospital is now covered speaks volumes for the excellent practices taking place."

PDU accreditation is awarded by Bournemouth University's health and social care

### Future developments

Poole Hospital is a high performing acute trust – more productive and efficient on a range of measures than most other NHS trusts of a similar size.

In the early part of 2011/12, Poole Hospital undertook a review of its strategic direction in the light of the challenges and opportunities presented by the changes set out in the new NHS white paper 'excellence and equity: liberating the NHS'. This review was undertaken to consider the needs of the communities served by Poole Hospital within the context of the five supporting strategic goals which guided the development of the strategy. These are to:

- Deliver the highest possible standard of patient-centred healthcare and contribute to improving the health and wellbeing of the population
- Provide a range of high quality NHS health services in the hospital and community
- Employ and engage a highly motivated, appropriately skilled workforce, seeking to improve employee satisfaction
- Involve patients, the public and partners in developing patient-centred seamless services
- Maintain financial viability

In terms of the longer-term strategic objectives for Poole Hospital, it became clear as part of this review that the drive to improve productivity and efficiency within the NHS necessitated the need to consider a possible merger with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Following an in-depth analysis of both the clinical and financial issues and

challenges facing both organisations, on 29 November 2011 the two organisations announced their intention to develop a proposal to merge.

In terms of continuing to deliver high quality, safe and cost effective services regardless of the outcome of the merger proposal, the trust agreed the following investments to enhance the quality of services delivered to patients:

- Information management and technology developments to support patient care
- Maternity and neonatal intensive care unit capital and staff investment
- Radiotherapy bunker capital investment
- Private patient facilities to generate income to invest in NHS services

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## Trends and factors

Poole Hospital recognises that healthcare is changing. The main issues in delivering sustainable and high quality patient care to the population served by the trust include:

### National drivers

- People are living longer, increasingly with acute, chronic and long term conditions including respiratory disorders and diabetes. These people use health services the most, and account for four out of five GP visits and one in three hospital bed stays. The current NHS can be better organised to treat people with long term illnesses in their homes and in the community to keep them well and out of hospital.

- Increasing specialisation of healthcare services. Healthcare is becoming increasingly specialised with teams of doctors and nurses being able to treat more and more people through the development of specialist skills and the use of specialist equipment. In order to build these specialist teams, they need to work effectively together and to build experience. It is not possible to do this if staff are spread thinly across multiple sites. It is also not possible to invest in specialist equipment that would enhance the services that we offer to patients. Our communities rightly expect us to provide the safest and highest quality services and be treated by the most appropriate healthcare professional.

- The NHS needs to do more with less - the small rise in NHS funding simply can't keep pace with the costs of providing such services. This is akin to a household's income remaining static while bills rise by a quarter. Savings and new ways of working are needed in order to continue to offer the services our communities need. In essence, patients should be treated by the right clinician, at the right time, in the right place.

### Clinical drivers

- Royal Colleges and national guidance for high quality, increasingly specialised services has established the need for increasing direct consultant input out of hours seven days a week, and in some specialties 24/7 consultant delivered patient care.

- In many areas of acute care, it is clear that the more quickly specialist treatment is initiated, the better the clinical outcome for patients

- Workforce trends and a need to adhere to EU working hours directives will make rotas in some services unsustainable

- The national and international trend to deliver more care closer to a patient's home

- The way services are funded requires all healthcare providers to increase productivity and to be more efficient.

**Local drivers**

- Poole Hospital needs to deliver savings of circa £26m by 2014/15. We have already made a start on addressing these challenges by working together with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and developing plans to reduce the costs of 'back office' services. We must also look at the opportunities that merger provides for reshaping healthcare delivery in the future

- Doctors in both trusts have worked together closely over the last few months and believe that by merging we can achieve the strongest position and greatest opportunity to successfully respond to these challenges

- The patient benefits of the merger are substantial, and will be delivered in the short and medium term. This is because merger will allow us to:

  a) enable higher quality and better integrated care across a range of services;
  b) operate at a more clinically optimal scale; and
  c) protect and increase the clinical quality of the services we provide, despite significant pressure on NHS funding

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**Risk**

Poole Hospital has a well-developed risk management and safety structure with a designated executive director lead. The executive lead chairs a risk management and safety group that reports to the hospital executive group (HEG) and is scrutinised by the audit and governance committee.

We have a risk management team with leads for clinical risk, health and safety and non-clinical risk. Across the Trust there are risk management leads in each clinical division and directorate. There is a robust assessment of risks to the organisation, which are recorded on a 'live' risk register which is reviewed regularly by a risk review group. The risk register is reported to the board of directors, audit and governance committee and the quality, safety and performance committee on a regular basis.

The key strategic risks are reported to and reviewed by the board of directors at each of their meetings. All new risks to the organisation are reviewed by a high-level risk review group and, once validated, are reported to the audit and governance committee and clinical risks to the quality, safety and performance committee. The risk management and safety group reviews all new risks on a monthly basis. Risks to our strategic objectives are highlighted in our assurance framework and any gaps in assurance identified.

The approach to risk was validated by the NHS Litigation Authority during its assessment of the Trust in May 2010. The Trust achieved the highest level of accreditation at this assessment and has maintained this level during 2011/2012.

The main risks to Poole Hospital NHS Foundation Trust last year were outlined in our strategic risk matrix, with a total of 18 risks identified. The key potential risks related to:

- Failure to achieve financial targets in 2011/2012
- Governance arrangements do not satisfy our regulator, Monitor
- Failure to achieve national performance targets, for example accident and emergency and cancer waiting times
- Payment by results tariff and block contract will adversely affect Trust income
- Potential disenfranchisement of staff and staff organisations due to pace of change and nature of change required by Trust
- Workforce requirements (regulatory) becoming unaffordable or unachievable
- Partnership working with external organisations will deteriorate as financial challenges grow.

The Trust has successfully mitigated these risks and although not all have been closed, many have had the level of risk reduced.

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## Staff sickness

In 2011/12 the Trust's target for sickness absence was retained at 3.5 per cent, the same as in 2010/11. At year end, this target was narrowly missed at 3.64 per cent. Nevertheless, this is the third lowest rate recorded by the Trust for more than 10 years. This year's rate was adversely affected by high incidences of viral illnesses, including norovirus, in the community.

The table below shows the rates experienced month by month during 2011/12.

| Apr 11 | May 11 | Jun 11 | Jul 11 | Aug 11 | Sep 11 | Oct 11 | Nov 11 | Dec 11 | Jan 12 | Feb 12 | Mar 12 | Year End |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.34% | 3.44% | 3.73% | 3.86% | 3.68% | 3.73% | 3.58% | 3.76% | 3.84% | 3.64% | 3.85% | 3.28% | 3.64% |

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## Occupational health

The Trust has an in-house occupational health service, staffed by a team of registered nurses and administrative staff. Medical support to the service is provided by two local general practitioners.

Amongst the services offered by occupational health are a range of employment-related services to the Trust including pre-employment screening, individual casework such as return to work assessments and management referrals, 'needle-stick' (hypodermic needle) injuries, workplace assessments, control of substances hazardous to health (COSHH) assessments and surveillance, and an annual flu vaccination programme.

The Trust offers an employee assistance programme, providing a range of expert support including counselling, through our partners, Validium.

The Trust is now working closely with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust occupational health senior team to develop a collaborative model which will enhance the team's capacity and enable the service to be provided across both sites under one senior occupational health lead. This will provide additional capability, clinical expertise and an improved overall service.

## Mandatory Employment Checks

The human resources (HR) department commenced a project in 2011/12 as part of routine assurance checks and reviews on workforce data and HR records looking at compliance in relation to mandatory employment checks.

The HR team is currently carrying out an update exercise on all personnel files and electronic records to ensure full compliance records are held as required by law, Department of Health policy and the Care Quality Commission.

## Going concern

The Trust has prepared the financial statements on a going concern basis. In light of the possible merger with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, the trust has considered whether the principle of going concern is appropriate for its circumstances.

The foundation trust annual reporting manual states that the financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

Should the merger with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust proceed, this will be on the basis that the services currently provided by the Trust will be transferred to the new FT which would be formed following the merger.

As work on the possible merger progresses, the Trust has also developed financial plans for the next three years, as part of the annual planning process, which demonstrates the Trust is financially sustainable. As such the Trust believes it is appropriate to prepare the accounts on a going concern basis.

## Audit information

As far as the directors of Poole Hospital NHS Foundation Trust are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all of 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 auditors are aware of that information.

The auditor has not provided non-audit services to the trust, however there is a policy in place, approved by the board of directors, should this be required.

## Relationships

Poole Hospital has excellent working relationships with each of its two main commissioning Primary Care Trusts (PCTs), NHS Bournemouth and Poole and NHS Dorset, which now work together as a single commissioning organisation to commission services for both populations.

The two Trusts together commission services for almost 98 per cent of our patients. With the development of GP clinical commissioning groups, the trust will continue to build on its good relationship with primary care throughout 2012/13.

We enjoy a close association with NHS South West, other local NHS organisations, the voluntary sector and our local politicians. The Trust relates to three local authorities – the Borough of Poole, Bournemouth Borough Council and Dorset County Council. Each authority has a health overview and scrutiny committee and the hospital has established good relationships with each. We also have a strong network of patient interest groups, particularly for cancer, cardiac and respiratory care, child health and diabetes.

Poole Hospital has a close working relationship with Bournemouth University, which supports our education and research functions. Each of the three local authorities, two PCTs and Bournemouth University have an appointed governor to the council of governors.

# Governance and membership report

## Introduction

As a foundation trust, Poole Hospital is run by a board of directors. This is made up of executive and non-executive directors. The board of directors is responsible for setting and achieving the long term strategic goals and key objectives of the foundation trust and ensuring that it meets its terms of authorisation.

The council of governors (CoG) is made up of 14 public governors and four staff governors, who are democratically elected by members of the foundation trust. There are also six appointed governors from our major partnership organisations. The CoG is responsible for ensuring that the foundation trust responds to the needs and preferences of stakeholders. Whilst not involved in the day-to-day running of the trust, governors provide an essential link between our board of directors, which is responsible for overseeing the delivery of services, its members (who are the local owners of the trust) and the community we serve.

## Board of directors

The board of directors is made up of full-time executive directors and part-time non-executive directors. The board usually meets once a month (excluding August and December) and its role is to determine the overall corporate direction of the trust and ensure delivery of our goals.

The board has reserved powers to itself covering:

- Regulation and control
- Appointments
- Strategy, business plans and budgets
- Direct operational decisions
- Financial and performance reporting arrangements
- Audit arrangements
- General enabling provision to determine any matter within its statutory powers

The board delegates areas of its powers to its sub-committees (not including executive powers unless expressly authorised). The schedule of delegation for the board sub-committees and for the executive committee of the trust is set out in standing orders.

The board has given careful consideration to the range of skills and experience required for the running of an NHS foundation trust and confirms that the necessary balance and completeness has been in place during the year under report, other than that during periods when vacancies have arisen.

## Role of the chairman

- Building a well balanced and effective board
- Chairing board and CoG meetings, and setting the board and CoG agendas
- Ensuring annual review of the board, council and the non-executive directors is undertaken
- Encouraging constructive challenge at board meetings
- Ensuring appropriate induction and development programmes for the board and Council
- Ensuring effective two way communication between the board and council members
- Promoting high standards of corporate governance.

**Role of the chief executive**

- The accounting officer for the trust
- Developing and implementing the trust's strategic direction and vision statement
- Recommending the annual and strategic plans for the trust
- Providing leadership to the trust
- Managing the trust's risk register and establishing internal controls
- Reviewing the trust's organisational structure and developing the executive directors
- Ensuring that the chairman and board are kept advised and up to date on trust business and wider healthcare policy and developments
- Maintaining relationships with the CoG
- Chairing the hospital executive group (HEG) of executive and clinical directors, responsible for delivering the trust's strategic objectives, operational management, service planning and advising the board of directors.

In 2007 the trust produced a formal statement regarding the division of responsibilities between the chairman and chief executive as required by Monitor's code of governance and this can be found on our website:
http://www.poole.nhs.uk/about_us/foundation_trust_governance_arrangements/documents/D23-ChairmanvChiefExecutiveResposibilitiesStatement_000.pdf

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**Role of the non-executive directors**

- Providing effective challenge at the board
- Assisting in the development of strategic focus for the trust bringing individual expertise
- Serving on the board sub-committees
- Assisting with senior clinical appointment panels for the trust.

If required, the chairman and non-executive directors may be removed by agreement at a general meeting of the CoG.

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**Role of the executive directors**

- Supporting the chief executive in implementing the trust's strategic direction and vision
- Ensuring that performance and quality targets are met
- Providing leadership for the day to day running of the trust
- Implementing the trust's annual plan
- Mitigating risks within the trust to ensure internal controls
- Reviewing individual organisational structures to ensure succession planning.

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**Role of the vice-chairman**

- Chairing board and CoG meetings in the absence of the chairman
- Supporting the chairman on board related matters as required
- Assisting with the chairman's day to day role in times of absence.

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**Role of the senior independent director**

- Being available to governors and members on matters which cannot be resolved by the chairman or chief executive
- Being involved in the process for evaluating the performance of the chairman
- Leading a meeting of the non-executive directors to evaluate the chairman's performance, as part of the process agreed with the CoG for appraising the chairman
- Liaising with the chairman, and company secretary, in relation to setting the agenda of the CoG.

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**Board evaluation**

The performance of individual directors is evaluated by annual appraisal. The process for the appraisal of the chairman and non-executive directors is approved by the CoG.

Evaluation of the board and its committees is undertaken annually and by external review regularly. The evaluation process is led by the chairman.

In 2011/12, the external assessors presented to the board of directors a board evaluation review. The outcome was positive, noting the significant improvements the trust had made since the last review. An action plan was developed from the outcomes of the review focusing on the areas that needed strengthening.

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**Board development**

The board has continued its on-going development through existing board seminars. Topics covered included the strategic direction for the trust, risk management, the future clinical strategy, planning assumption, future configuration, merger and workforce development.

As a newly-appointed non-executive director, Nick Ziebland attended trust induction and was provided with a comprehensive local induction.

The board also attended a joint workshop with the governors in January 2012 which informed a governor development plan, this session focused on how the board could develop the support to the governors to undertake their required role.

The board also undertook, in January 2012, a special board development session which included the outputs from the governor workshop and planning for the proposed merger.

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**Key activities of the board**

During the year, the board discussed and agreed a new committee in line with one of the outcomes from the board review. The workforce committee, whose focus is to ensure capability and capacity for the future workforce, met for the first time in shadow form in October 2011.

There were discussions on a possible merger with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and a joint statement of intent was presented to the June 2011 meeting, with a decision to make an application for merger taken in November 2011.

The board supported the chief operating officer and finance director with a review of the trust's performance report to make it more integrated and comprehensive.

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**Working with governors**

The trust has a formal engagement document that sets out how the board of directors works with the CoG to ensure the directors have an understanding of the views of governors and members and is invited to the CoG meetings. The document underlines the importance of frequent informal communication in building a positive and constructive relationship, and outlines formal communication methods and can be found on our website:

http://www.poole.nhs.uk/about_us/foundation_trust_governance_arrangements/documents/D7-BoardPolicyforengagementwithCoG2010_001.pdf

Communications between the CoG and the board may occur with regard to, but shall not be limited to:

- The board of directors' proposals for the strategic direction of the trust and the annual plan
- The board of directors' proposals for developments
- Trust performance
- Involvement in service reviews and evaluation relating to the trust's services.

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## Members of the board of directors

**Angela Schofield, chairman**

Date of appointment: 16 May 2011
Date of expiry: 15 May 2014

Angela was appointed as chairman by the CoG and took up the role of chairman in May 2011 for a three-year tenure of office.

Angela joined the trust from her previous position as chairman of NHS Bournemouth and Poole. She also has close links with Bournemouth University where she was joint head of school at the Institute of Health and Community Studies. She has also previously been vice-chair of Bournemouth Teaching Primary Care Trust.

Angela has a professional background as a healthcare manager. Formerly chief executive of an NHS trust in Yorkshire and general manager of Poole Bay Primary Care Group, she has also held academic posts at the Health Services Management Unit, at the University of Manchester.

Angela lives in Charlton Marshall.

***Other directorships and registered interests****
Trustee, Brendon Care
***Other committee memberships***
Appointments committee
Council of governors
Finance and investment committee
Nominations, remuneration and evaluation committee
Remuneration committee

**Dame Yvonne Moores, interim chairman from 1 December 2010-15 May 2011; non-executive director; vice-chairman, quality, safety and performance committee**

Date of appointment: 1 November 2006
Date of expiry: 31 October 2013

From 1982 to 1999, Yvonne was the chief nursing officer for Wales, Scotland and England. In the last of these three posts, she was also a director of the NHS Executive with particular responsibility for quality issues. She chaired the council of Southampton University for a six-year period, and is currently pro-chancellor of Bournemouth University. She is currently the chair of the National House Building Council's pensions board. She is an international adviser to Thailand's Princess Srinagarindra Foundation and a patron of the Poole Africa Link charity.

Yvonne lives in Ferndown.

***Other directorships and registered interests****
Pro-chancellor – Bournemouth University
Chair – National House Building Council pensions board
Patron – Poole Africa Link
Non-majority shareholder in Glaxo SmithKline
Non-majority shareholdings in Source BioServices

***Other committee memberships***
Appointments committee
Audit and governance committee
Quality, safety and performance committee
Remuneration committee

**Jean Lang DL, non-executive director; chairman, audit and governance committee**

Date of appointment: 1 December 2006
Date of expiry: 30 November 2013

Jean was a solicitor in private practice in Dorchester. She was a non-executive director of the South West Dorset Primary Care Trust from 2001 to 2006. She was also a member of the Dorset Police Authority between 1996 and 2007 and chairman of its audit and performance review committee since 1998. Since retiring from private practice Jean sits as a tribunal judge in the Social Entitlement Chamber.

Jean lives in Dorchester.

***Other directorships and registered interests****
Director - Voluntary Sector Support and Training Limited
Trustee - The Roberts Trust

***Other committee memberships***
Appointments committee
Audit and governance committee
Remuneration committee
Workforce committee

**Ian Marshall, non-executive director**

Date of appointment: 1 February 2011
Date of expiry: 31 January 2014

Ian is a chartered accountant and has worked in industry, banking and insurance for the past 40 years, moving to non-executive director roles in the mid 1990s. He is currently chairman of a Lloyds of London insurance syndicate which insures marine, energy, professional liability and other commercial risks. In 2008 he was appointed as a senior advisor to the Financial Services Authority, where he advises on board and governance matters. Apart from commercial appointments, Ian is honorary treasurer and council member of the children's charity Barnardo's, and an active worker with two microfinance charities in Malawi, where he visits twice a year.

Ian lives in Poole with his wife and has four grown-up children.

***Other directorships and registered interests****
Non-executive director – Barnardo's (honorary treasurer)
Non-executive director – Micro Enterprise Africa Limited
Director – Markel Syndicate Management Limited
Director – Markel International Insurance Company Limited
Director – Ian Marshall Limited

***Other Committee Memberships***
Appointments committee
Audit and governance committee
Finance and investment committee
Remuneration committee

**Michael Mitchell, non-executive director; chairman, finance and investment committee**

Date of appointment: 1 November 2010
Date of expiry: 31 October 2013

Michael was chief executive of the department store group Beale plc from 1982 to 2002. Since 2002 he has been a non-executive director and consultant in both the private and public sectors. Currently he is a Poole Harbour Commissioner, a director of Old and Campbell Ltd, and Chairman of Goulds (Dorchester) Ltd.

Michael lives in Bournemouth.

***Other directorships and registered interests****
Director – Goulds (Dorchester) Ltd
Director – Old & Campbell Ltd
Poole Harbour Commissioner
General management consultancy

***Other committee memberships***
Appointments committee
Finance and investment committee
Remuneration committee

**Guy Spencer, non-executive director/senior independent director; chairman, workforce committee**

Date of appointment: 25 April 2008
Date of expiry: 24 April 2014

Guy was environmental services director at Dorset County Council from 1996-2001. He has been a board member of Bournemouth and Poole College since 1999 and an independent transportation consultant since 2001.

Guy lives in Broadstone.

***Other directorships and registered interests****
Board member – Bournemouth & Poole College
Daughter is a finance manager at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Son is coordinator with Borough of Poole drug and alcohol action team
Son-in-law is a director of Hampshire and Isle of Wight PCT

***Other committee memberships***
Appointments committee
Audit and governance committee
Remuneration committee
Workforce committee

**Nick Ziebland, non-executive director**

Date of appointment: 31 August 2011
Date of expiry: 30 August 2014

Nick is a former executive at the British Airports Authority (BAA), having previously worked for companies including J Sainsbury and Imperial Group. He has also served as a non-executive director for the South East Coast Strategic Health Authority and as an independent committee member for Dorset Community Health Services.

Nick lives near Bridport.

***Other directorships and registered Interests****
Non-executive director – Local Food Links

***Other committee memberships***
Appointments committee
Quality, safety and performance committee
Remuneration committee
Workforce committee

**Elizabeth Hall, non-executive director**

Date of appointment: 1 February 2003
Date of termination: 30 June 2011

Elizabeth was a chartered accountant and tax specialist before she stopped working full-time to bring up her family. Subsequently over a period of 14 years she served as chair of finance, deputy chairman and responsible officer at a large grant-maintained comprehensive school. She is a magistrate, acts as co-ordinating appraiser for the East Dorset Bench and prior to its dissolution, served for several years on the Magistrates' Courts Committee for Dorset.

**Chris Bown, chief executive**

Date of appointment: 1 April 2010

Chris has a wealth of experience in the management of NHS acute hospitals. Prior to taking up his appointment at Poole Hospital, he was Chief Executive at West Suffolk Hospital NHS Trust in Bury St Edmunds. Previously Chris worked as Director of Operations at Birmingham Children's Hospital and in London teaching hospitals. He has Board-level experience in the management and development of clinical services, organisational turnaround, business, strategic development and change, capital planning, commissioning and human resource management.

Chris was born in Dorset and has strong family ties in the area.

***Other directorships and registered Interests****
Nil

***Other committee memberships***
Appointments committee
Finance and investment committee

**Gareth Corser, director of strategy and business development**

Date of appointment: 1 August 2011

Gareth began his NHS career as a management trainee, and has nearly two decades of experience in the NHS, working in strategic, planning and partnership development roles in acute hospitals in Suffolk and Birmingham, as well as in PCT and commissioning services.

***Other directorships and registered interests****
Nil

***Other committee memberships***
Nil

**Mary Sherry, chief operating officer**

Date of appointment: 10 January 2011

Mary joined the NHS in 1986, working in general management across a range of specialties at Kingston Hospital and St George's Hospital over the following 10 years. She went on to undertake a number of corporate roles at Surrey & Sussex NHS Trust and Portsmouth Hospitals NHS Trust, focusing on service redesign, reducing waiting times, working closely with hospital clinicians, GPs and partner organisations to review and improve pathways for patients. At Portsmouth as Head of Operations, and subsequently Associate Director, she led the operational planning of the three sites into one reconfiguration and new build project which was completed in 2009. She was subsequently appointed as Director at Queen Victoria Hospital Foundation Trust, leading the development of their transformation plan.

***Other directorships and registered interests****
Nil

***Other committee memberships***
Finance and Investment Committee
Quality, Safety and Performance Committee
Workforce Committee

**Martin Smits, director of nursing and patient services**

Date of appointment: 6 January 2003

Martin trained as a nurse in London following completion of a degree in Geology and Economics. He was 'sister' of a large medical ward at St George's Hospital and then moved to St Thomas' Hospital as a Senior Nurse. He completed his Master's degree in 1984 and published his first book in 1988. He then moved south to work as assistant chief nurse in Brighton, becoming director of nursing there in 1990. Martin moved to Worthing as matron/deputy chief executive in 1994 followed by a secondment to Eastbourne Hospitals in 2001 to re-establish nursing after a period of difficulty. He took up post at Poole Hospital at the beginning of 2003.

***Other directorships and registered interests****
Doctoral student at University of Brighton
Wife is a nurse at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

***Other committee memberships***
Quality, safety and performance committee
Workforce committee

**Mr Robert Talbot, medical director**

Date of Appointment: 1 April 2008

Robert is a consultant colorectal surgeon who established the department of colorectal surgery at Poole Hospital. Robert was visiting scientist at the Mayo Clinic, Rochester, Minnesota, and a fellow at St Mark's Hospital for Diseases of the Colon and Rectum. He was medical director of the Dorset Cancer Network from 2003 until 2008.

***Other Directorships and Registered Interests****
Wife is matron in oncology at Poole Hospital

***Other Committee Memberships***
Quality, safety and performance committee
Workforce committee

**Paul Turner, director of finance**

Date of appointment: 13 September 2010

Paul joined the trust in September 2010. He is a qualified chartered accountant (FCA) who has been an executive director within the NHS for 18 years, including 13 years as director of finance of four different acute trusts and five years as chief executive of a community Trust/primary care Trust. Before joining the NHS, Paul worked in the private sector, including six years as a management consultant for one of the major international accountancy firms.

***Other directorships and registered interests****
Nil

***Other committee memberships***
Finance and investment committee

**Philip James, director of human resources**

Date of Appointment: 1 December 2009 to 1 April 2011

In addition, Sarah Jane Taylor, director of human resources and organisational development serves on the board in a non-voting capacity. Carrie Gilmore, acting human resources director, similarly served on the board as a non-voting member until 12 May 2012.

*Interests recorded as at 31 March 2012.

In compliance with paragraph C.1.13 of the Monitor code of governance for NHS foundation trusts, no executive director holds more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.

The board of directors has paid due attention to clause 27 of the constitution and its standing orders (annex 7 item 7.1.2) and has decided that the declared interests with the local

university by Dame Yvonne Moores did not affect the effectiveness and impartiality of the board and therefore all the non-executive directors are determined as independent.

All non-executive directors were appointed following open competition, except Jean Lang who was appointed by the Appointments Commission as she was already in post when the hospital became a foundation trust.

The chairman has no other significant commitments.

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## ATTENDANCE AT BOARD OF DIRECTORS' MEETINGS 2011/2012

| **Name of committee:** | **Board of Directors** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Membership (as per Terms of Reference).** | **Meeting Dates** | | | | | | | | | | | |
| | **April 2011** | **May 2011** | **June 2011**[1] | **June 2011** | **July 2011** | **September 2011** | **October 2011** | **November 2011** | **December 2011*** | **January 2012** | **February 2012** | **March 2012** |
| Angela Schofield[2] Chairman | | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Chris Bown Chief Executive | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Gareth Corser[4] Director of Strategy | | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Elizabeth Hall [3] Non-Executive Director | ✓ | ✓ | ✓ | ✓ | | | | | | | | |
| Jean Lang Non-Executive Director | ✓ | x | x | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ |
| Ian Marshall Non-Executive Director | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x | ✓ |
| Michael Mitchell Non-Executive Director | ✓ | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Yvonne Moores Non-Executive Director/ Vice Chairman | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mary Sherry Chief Operating Officer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Martin Smits Director of Nursing and Patient Services | ✓ | ✓ | x | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ |
| Guy Spencer Non-Executive Director/SID | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Robert Talbot Medical Director | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Paul Turner Director of Finance | ✓ | ✓ | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Nick Ziebland[5] Non-Executive Director | | | | | | x | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Was the meeting quorate? **Y/N** | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |

** Special Meeting*

[1] *Extra Part 2 meeting*
[2] *Angela Schofield was appointed Chairman 16 May 2011*
[3] *Elizabeth Hall resigned as a Non-Executive Director from 30 June 2011*
[4] *Gareth Corser was appointed Director of Strategy from 1 August 2011*
[5] *Nick Ziebland was appointed as a Non-Executive Director from 31 August 2011*

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## AUDIT AND GOVERNANCE COMMITTEE

### Chair: Jean Lang, non-executive director

The audit and governance committee, which consists of four non-executive directors of the trust, other than the chairman, has an important role to play in ensuring we conduct our financial affairs within an environment of honesty and integrity.

The main objectives of the committee are to ensure that the trust's activities are within the law and regulations covering the NHS and that an effective internal financial control system is maintained.

The committee must be able to assure the board of directors that the system of internal control is operating effectively and that there are clear processes to ensure that proper risk and governance procedures are in place.

### Internal Audit

Internal auditors assist the audit and governance committee by providing a clear statement of assurance regarding the adequacy and effectiveness of internal controls. The director of finance is professionally responsible for implementing systems of internal financial control and is able to advise the audit and governance committee on such matters.

### External Auditors

In September 2008, the council of governors (CoG) approved the appointment of PricewaterhouseCoopers LLP to succeed the Audit Commission as external auditors and in October 2011 the CoG approved a two year extension. The role of external auditors is to provide an independent audit opinion on the annual report and accounts, as well as providing a limited assurance opinion on the quality report.

The audit and governance committee meets five times a year.

## ATTENDANCE AT AUDIT AND GOVERNANCE COMMITTEE 2011/2012

| **Name of committee:** | **Audit and Governance Committee** | | | | |
|---|---|---|---|---|---|
| **Reports to :** | **Board of Directors** | | | | |
| **Membership (as per Terms of Reference).** | **Meeting Dates** | | | | |
| | **June 2011** | **September 2011** | **November 2011** | **January 2012** | **March 2012** |
| Jean Lang<br>Chairman Non-Executive Director | x | ✓ | ✓ | ✓ | ✓ |
| Elizabeth Hall*<br>Non-Executive Director | ✓ | | | | |
| Ian Marshall<br>Non-Executive Director | x | x | ✓ | x | x |
| Yvonne Moores<br>Non-Executive Director | | ✓ | ✓ | ✓ | x |
| Guy Spencer<br>Non-Executive Director | ✓ | ✓ | ✓ | ✓ | ✓ |
| **In attendance:** | | | | | |
| Angela Schofield (Trust Chairman) | | ✓ | N/A | N/A | N/A |
| *Executive Directors/Deputies* | 3 | 5 | 2 | 2 | 2 |
| *External Audit** | 2 | 1 | 2 | 2 | 2 |
| *Internal Audit* | 1 | 2 | 2 | 2 | 2 |
| *Counter Fraud* | 1 | 0 | 1 | 1 | 1 |

| Was the meeting quorate? **Y / N** | Y | Y | Y | Y | Y |
|---|---|---|---|---|---|

* Elizabeth Hall left the Trust on 30 June 2012

## FINANCE AND INVESTMENT COMMITTEE

The finance and investment committee is a sub-committee of the board of directors.

The committee receives detailed monthly financial reports so that it can ensure the use of our financial resources is robust. It sets the policy for and scrutinises cash investments, reviews detailed business cases, oversees the progress of agreed capital investments and reviews financial planning and budgeting processes.

Membership is made up of a non-executive director (chairman), director of finance (vice-chairman), chief operating officer, chief executive and two other non-executive directors. Other senior managers may attend on an ad hoc basis as requested by the committee.

The committee meets at least monthly (except in August and December) prior to the board meeting, or more frequently if required.

## FINANCE AND INVESTMENT COMMITTEE ATTENDANCE 2011/2012

| **Name of committee:** | Finance and Investment Committee | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Reports to :** | Board of Directors | | | | | | | | | | | |
| **Membership (as per Terms of Reference).** | **Meeting Dates** | | | | | | | | | | | |
| | **April 2011** | **May 2011** | **June 2011** | **July 2011** | **August 2011** | **September 2011** | **October 2011** | **November 2011** | **December 2011** | **January 2012** | **February 2012** | **March 2012** |
| Michael Mitchell<br>Chairman Non-Executive Director | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Ian Marshall<br>Non-Executive Director | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | x | ✓ |
| Yvonne Moores<br>Interim Chair | ✓ | | | | | | | | | | | |
| Angela Schofield*<br>Chairman | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mary Sherry<br>Chief Operating Officer | ✓ | ✓ | x | x | | ✓ | x | ✓ | x | ✓ | x | ✓ |
| Paul Turner<br>Director of Finance | ✓ | ✓ | ✓ | x | | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ |
| Gareth Corser[1]<br>Director of Strategy | | | | | | | ✓ | x | x | x | | |
| Chris Bown[2]<br>Chief Executive | | | | | | | | | | | ✓ | ✓ |
| Was the meeting quorate? Y/N | Y | Y | N | Y | N/A | Y | N | Y | Y | Y | Y | Y |

* Angela Schofield was appointed Chairman and replaced Yvonne Moores on the Committee
[1] Gareth Corser joined the committee from October 2011
[2] Chris Bown replaced Gareth Corser's membership from February 2012

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## QUALITY, SAFETY AND PERFORMANCE COMMITTEE

The quality, safety and performance committee is a sub-committee of the board of directors.

The committee receives detailed quality, safety and performance reports so that it can ensure that patient safety and quality of services meet registrations and compliance requirements.

Membership of the committee comprises three non-executive directors (one of which chairs the committee), the director of nursing and patient services, medical director and chief operating officer.

The committee meets bi-monthly, or more frequently if required.

### QUALITY AND SAFETY COMMITTEE ATTENDANCE REGISTER 2011/2012

| **Name of committee:** | **Quality, Safety and Performance Committee** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Reports to :** | **Board of Directors** | | | | | | | |
| **Membership (as per Terms of Reference).** | **Meeting Dates** | | | | | | | |
| | **April 2011** | **May 2011** | **June 2011** | **July 2011** | **September 2011** | **November 2011** | **January 2012** | **March 2012** |
| Yvonne Moores<br>Chairman Non-Executive Director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Carrie Gilmore<br>Interim Director of HR | x | | | | | | | |
| Jean Lang<br>Non-Executive Director | ✓ | x | ✓ | ✓ | x | | | |
| Debi Reeves[2]<br>Interim Director of HR | | | | ✓ | ✓ | ✓ | | |
| Mary Sherry<br>Chief Operating Officer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Martin Smits<br>Director of Nursing & Patient Services | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Robert Talbot<br>Medical Director | ✓ | ✓ | x | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sarah Jane Taylor[1]<br>Director of Human Resources and Organisational Development | | ✓ | ✓ | | | | | |
| Nick Ziebland<br>Non-Executive Director | | | | | | ✓ | ✓ | ✓ |
| Was the meeting quorate? Y/N | Y | Y | Y | Y | Y | Y | Y | Y |

[1] Sarah Jane Taylor joined the Trust in May 2011
[2] Debi Reeves covered for Sarah-Jane Taylor for a period of leave.

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## WORKFORCE COMMITTEE

The workforce committee is a sub-committee of the board of directors.

The committee receives detailed workforce related reports so that it can ensure that workforce capacity and capability is assured for the future strategic direction of the trust.

Membership of the committee comprises of three non-executive directors (one of which chairs the committee), the director of human resources and organisational development, director of nursing and patient services, medical director and chief operating officer.

### WORKFORCE COMMITTEE ATTENDANCE REGISTER 2011/2012

| **Name of Committee:** | **Workforce Committee** | | |
|---|---|---|---|
| **Reports to :** | **Board of Directors** | | |
| **Membership (as per Terms of Reference).** | **Meeting Dates** | | |
| | **October 2011*** | **December 2011** | **February 2012** |
| Guy Spencer<br>Chairman Non-Executive Director | ✓ | ✓ | ✓ |
| Jean Lang<br>Non-Executive Director | x | x | ✓ |
| Debi Reeves<br>Interim Director of Human Resources | ✓ | ✓ | |
| Mary Sherry<br>Chief Operating Officer | x | x | x |
| Martin Smits<br>Director of Nursing & Patient Services | x | ✓ | ✓ |
| Robert Talbot<br>Medical Director | x | ✓ | x |
| Sarah-Jane Taylor<br>Director of Human Resources and Organisational Development | | | ✓ |
| Nick Ziebland<br>Non-Executive Director | ✓ | ✓ | ✓ |
| Was the meeting quorate? Y/N | N/A | Y | Y |

* Shadow meeting of the committee

## APPOINTMENTS COMMITTEE

The appointments committee makes the executive appointment to the board of directors. It is made up of the chairman and non-executive directors of the board of directors. The director of human resources and organisational development attends except when his/her own appointment is discussed. The chief executive attends except when his/her own appointment is discussed.

The committee met on 29 July 2011 to approve the appointments made on 12 April 2011 of the director of human resources and organisational development and on 28 April 2011 of the director of strategy and business development.

Appointments to executive director posts are made in open competition and can only be terminated by the board of directors.

### APPOINTMENTS COMMITTEE ATTENDANCE 2011/2012

| NAME OF COMMITTEE | APPOINTMENTS COMMITTEE |
|---|---|
| **REPORTS TO:** | **BOARD OF DIRECTORS** |
| **Membership (as per Terms of Reference)** | **Meeting Date** |
| | **29 July 2011** |
| ANGELA SCHOFIELD – Chairman | ✓ |
| YVONNE MOORES – Non-Executive Director | ✓ |
| JEAN LANG – Non-Executive Director | ✓ |
| IAN MARSHALL – Non-Executive Director | ✓ |
| MICHAEL MITCHELL – Non-Executive Director | ✓ |
| GUY SPENCER – Non-Executive Director | ✓ |
| ELIZABETH HALL – Non-Executive Director | ✓ |
| NICK ZIEBLAND – Non-Executive Director | |
| **In attendance** | |
| CHRIS BOWN – Chief Executive | x |
| SARAH-JANE TAYLOR – Director of HR & Organisational Development | ✓ |

## REMUNERATION REPORT (unaudited section)

The remuneration committee reviews the remuneration arrangements for executive directors and the company secretary. It is made up of the chairman of the board of directors and all the non-executive directors of the board. The director of human resources and organisational development attends except when his/her own salary is discussed. The chief executive attends only to advise on issues concerning the performance of directors. The committee met in May 2011 and June 2011, attendance is detailed below.

Pay levels are determined by salary surveys conducted by independent consultants and comparisons with salary scales for similar posts in other NHS organisations, and from information provided by the Foundation Trust Network. Executive directors' remuneration is managed through a process of objective setting and annual appraisals.

Directors hold substantive contracts with six-month notice periods. The remuneration committee, with regard to HM Treasury guidance, if appropriate, would agree termination payments.

| **NAME OF COMMITTEE:** | **REMUNERATION COMMITTEE** | |
|---|---|---|
| **REPORTS TO :** | **BOARD OF DIRECTORS** | |
| **Membership (as per Terms of Reference).** | **Meeting Dates** | |
| | **25 May 2011** | **29 June 2011** |
| ANGELA SCHOFIELD - Chairman | ✓ | ✓ |
| YVONNE MOORES – Non-Executive Director | ✓ | ✓ |
| JEAN LANG – Non-Executive Director | | ✓ |
| IAN MARSHALL – Non-Executive Director | ✓ | ✓ |
| MICHAEL MITCHELL – Non-Executive Director | | ✓ |
| ELIZABETH HALL – Non-Executive Director | x | ✓ |
| GUY SPENCER – Non-Executive Director | ✓ | ✓ |
| NICK ZIEBLAND – Non-Executive Director | | |
| **In Attendance** | | |
| SARAH-JANE TAYLOR – Director of HR and Organisational Development | ✓ | ✓ |
| CHRIS BOWN – Chief Executive | ✓ | x |

## Salary and pension entitlements of senior managers (audited section)

| Name and Title | 2011-12 Salary (bands of £5000) £000 | 2011-12 Other Remuneration (bands of £5000) £000 | 2011-12 Benefits in Kind (bands of £100) £100 Note 1 | 2011-12 Total (bands of £5000) | 2010-11 Salary (bands of £5000) £000 | 2010-11 Other Remuneration (bands of £5000) £000 | 2010-11 Benefits in Kind (bands of £100) £100 Note 1 | 2010-11 Total (bands of £5000) |
|---|---|---|---|---|---|---|---|---|
| **Chris Bown - Chief Executive** | 145-150 | **-** | **-** | **145-150** | 145-150 | **-** | **-** | **145-150** |
| **Gareth Corser - Director of Strategy and Business Development (Note 2)** | 65-70 | **-** | **-** | **65-70** | **-** | **-** | **-** | **65-70** |
| **Mary Sherry - Chief Operating Officer** | 110-115 | **-** | **-** | **110-115** | 20-25 | **-** | **-** | **20-25** |
| **Martin Smits - Director of Nursing** | 90-95 | **-** | **-** | **90-95** | 90-95 | **-** | **-** | **90-95** |
| **Mr Robert Talbot - Medical Director (Note 8)** | 85-90 | 85-90 | **-** | **170-180** | 85-90 | 85-90 | - | 170-180 |
| **Sarah-Jane Taylor - Director of HR and Organisational Development (Note 9)** | 65-70 | - | **-** | **65-70** | **-** | **-** | **-** | **-** |
| **Paul Turner - Director of Finance** | 125-130 | **-** | **-** | **125-130** | 65-70 | **-** | **-** | **65-70** |
| **Carrie Gilmore - Acting HR Director - non voting (Note 3)** | 25-30 | **-** | **-** | **25-30** | 90-95 | **-** | **-** | **90-95** |
| **Elizabeth Hall - Non Executive Director (Note 4)** | 0-5 | **-** | **-** | **0-5** | 10-15 | **-** | **-** | **10-15** |
| **Philip James - Director of Human Resources (Note 5)** | 40-45 | **-** | **-** | **40-45** | 90-95 | **-** | **-** | **90-95** |
| **Jean Lang - Non-Executive Director** | 15-20 | **-** | **-** | **15-20** | 15-20 | **-** | **-** | **15-20** |
| **Ian Marshall - Non Executive Director** | 10-15 | **-** | **-** | **10-15** | 0-5 | **-** | **-** | **0-5** |
| **Michael Mitchell - Non Executive Director** | 15-20 | **-** | **-** | **15-20** | 0-5 | **-** | **-** | **0-5** |
| **Dame Yvonne Moores - Non Executive Director and Interim Chair (Note 6)** | 15-20 | **-** | **-** | **15-20** | 20-25 | **-** | **-** | **20-25** |
| **Angela Schofield - Chairman (Note 7)** | 35-40 | **-** | **-** | **35-40** | **-** | **-** | **-** | **-** |
| **Guy Spencer - Non Executive Director** | 10-15 | **-** | **-** | **10-15** | 10-15 | **-** | **-** | **10-15** |
| **Nick Ziebland - Non Executive Director (Note 10)** | 5-10 | **-** | **-** | **5-10** | - | **-** | **-** | |

Note 1. Benefits in kind relate to the profit element on business mileage claimed.

Note 2. Gareth Corser was appointed as Director of Strategy and Business Development on 1 August 2011

Note 3. Carrie Gilmore was Acting Director of Human Resources (non-voting) and left the Trust on 12 May 2012. The costs above relate to payments for her services to an employment agency.

Note 4. Elizabeth Hall retired on 30 June 2011.

Note 5. Philip James left the Trust on 1 April 2011. The salary payment reflects his contractual entitlement due on cessation of contract.

Note 6. Dame Yvonne Moores acted as Interim Chair until 15 May 2011.

Note 7. Angela Schofield was appointed on 16 May 2011.

Note 8. Other remuneration relates to clinical work undertaken during the year.

Note 9. Sarah-Jane Taylor was appointed as a non-voting board member on 9 May 2011.
Note 10. Nick Ziebland was appointed on 31 August 2011.

## Pension entitlements of senior managers

| Name and title | Real increase in pension sum at age 60 (bands of £2500) £000 | Real increase in pension lump sum at age 60 (bands of £2500) £000 | Total accrued pension and related lump sum at age 60 at 31 March 2012 (bands of £5000) £000 | Cash Equivalent Transfer Value at 31 March 2012 £000 | Cash Equivalent Transfer Value at 1 April 2011 £000 | Real Increase in Cash Equivalent Transfer Value £000 |
|---|---|---|---|---|---|---|
| **Chris Bown - Chief Executive** | 0-2.5 | 0-2.5 | 215-220 | 1,015 | 895 | 93 |
| **Gareth Corser - Director of Strategy and Business Development** | 2.5-5 | 7.5-10 | 70-75 | 268 | 178 | 56 |
| **Martin Smits - Director of Nursing** | (0-2.5) | (0-2.5) | 155-160 | 832 | 771 | 37 |
| **Mary Sherry - Chief Operating Officer** | 0-2.5 | 2.5-5 | 120-125 | 629 | 554 | 57 |
| **Mr Robert Talbot - Medical Director** | 12.5-15 | 37.5-40 | 315-320 | n/a | 1,498 | n/a |
| **Sarah-Jane Taylor - Director of HR and Organisational Development (see Note)** | 0-2.5 | n/a | 5-10 | 53 | 27 | 17 |
| **Paul Turner - Director of Finance** | 0-2.5 | 2.5-5 | 125-130 | 750 | 677 | 52 |

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. 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 other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.
Additional disclosures, including the pension policy, can be found within the financial statements on senior manager pay in the audited accounts section of this report.

**Remuneration report – pay multiples**

The Hutton Review of Fair Pay Implementation required that a pay multiple be calculated as part of the remuneration report. Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director at Poole Hospital NHS Foundation Trust in the financial year 2011/12 was £175,000-£180,000. This was 7.5 times the median remuneration of the workforce, which was £23,589.

The median pay calculation is based on:

- Payments made to staff in post on 31 March 2012.

- The reported salary used to estimate the median pay is the gross cost to the Trust, less employers Pension and employers Social Security costs. The reported annual salary for each whole time equivalent has been estimated by using contracted values.

- Payments made in March 2012 to staff who were part-time were pro-rated to a whole time equivalent salary.

Included in the calculation is an estimated average cost for agency staff. All agency staff expenditure is processed through dedicated account codes on the financial system. The total March 2012 expenditure on these codes was used to estimate an average salary. This was calculated by dividing the total expenditure by the estimated number of agency staff used during the year. The number of agency staff is estimated by splitting agency expenditure into relevant categories. The total agency expenditure in each category will be divided by the average salary of Trust staff in the same category to estimate the number of agency staff. There has been no deduction made for agency fees for the provision of these staff.

The median salary has been calculated as the middle salary if salaries were ranked in ascending order, and equates to £23,589.

The highest paid director is excluded from the median pay calculation.

The highest paid director's remuneration is based on their total remuneration which includes all salaries and allowances (including director's fee), bonus payments and other remuneration.

Given that the calculation is based on contractual remuneration it is not possible to show a comparative prior year figure, as the data used is updated to reflect current contractual remuneration for staff such as staff movements and changes to contractual payments.

**Signed:**

**Chris Bown**
**Chief executive**
30 May 2012

## COUNCIL OF GOVERNORS

The council is made up of 18 elected public and staff governors, and six nominated by partner organisations.

The council plays a role in helping to set the overall strategic direction of the organisation by advising the board of directors of the views of the constituencies they represent. It also has specific responsibilities set out in the statute in relation to the appointment or removal of non-executive directors and their remuneration, the appointment or removal of the trust's auditors and development of the membership strategy.

The trust is committed to embedding transparency and accountability throughout, and believes that its robust and effective engagement policy should resolve any matters whereby the Governors would feel the need to inform Monitor of any potential breach of their terms of authorisation at the earliest practicable opportunity. We do not foresee the circumstances whereby it would be necessary for the Governors to have to inform Monitor of any possible breaches.

The council is chaired by the chairman of the trust, and Guy Spencer, non-executive director, is senior independent director.

The council's lead governor is Vivien Duckenfield, while James Pride is deputy chairman.

### During 2011/12 the council of governors was made up as follows:

Elected representatives for Bournemouth:
- Terence Purnell
- Brian Newman

Elected representatives for Poole:
- Emma Chamberlain
- Andrew Creamer
- Vivien Duckenfield, Lead Governor
- Richard King
- James Pride
- Elizabeth Purcell
- Gerald Rigler
- Sandra Yeoman

Elected representatives for Purbeck, East Dorset & Christchurch:
- Christopher Archibold
- Geoffrey Carleton
- Rosemary Gould

Elected representative for North Dorset, West Dorset, Weymouth and Portland:
- Isabel McLellan

Elected staff representatives:
- Lynn Cherrett (clinical staff)
- Kris Knudsen(clinical staff)
- Sue Power (clinical staff)
- Canon Jane LLoyd (non-clinical staff)

Nominated representatives from partner organisations:

- Graham Avis, NHS Dorset
- Judith Geddes, Bournemouth Borough Council (from 7 April 2011)
- Jenny Jenkin, Bournemouth University
- Cllr David Jones, Dorset County Council
- Glyn Smith, NHS Bournemouth & Poole
- Cllr Ann Stribley, Borough of Poole (from 27 June 2011)

**Elections**

A notice of election was published in February 2012 for two public seats:

- The public seat for the North Dorset, West Dorset, Weymouth and Portland constituency was uncontested and Mrs Isabel McLellan started her new three year term of office on 1 May, 2012.
- The second public seat is for Purbeck, East Dorset and Christchurch and the election closed on 20 April 2012.

**Governor expenses**

During the period of 2011/12 four governors claimed expenses for mileage and related car parking charges to attend meetings or training events locally and nationally*:

| Name | Total |
|---|---|
| Vivien Duckenfield | £64.00 |
| Brian Newman | £265.40 |
| Terence Purnell | £170.40 |
| Isabel McLellan | £307.50 |

* where possible Governors will car share.

Details of Governors' declaration of interests which relate to the business of the Trust can be viewed on our public website: http://www.poole.nhs.uk/about_us/governors/documents/E4RegisterofInterestsreportOct2011.pdf or contact the Board and Council Administrator, on 01202 442895.

## COUNCIL OF GOVERNORS 2011- 2012 ATTENDANCE REGISTER

| Name | Constituency | Type of M'ship | Appt Date | Re Appt Date | Appt Expires | Meeting Dates | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 7 April 2011 | 10 May 2011* | 7 July 2011 | 11 August 2011* | 6 October 2011[1] | 5 January 2012 |
| Mrs Angela Schofield | Chairman | | | | | | | ✓ | ✓ | ✓ | ✓ |
| Dame Yvonne Moores | Interim Chairman | | | | | ✓ | ✓ | | | | |
| Mr Christopher Archibold | Purbeck, East Dorset & Christchurch | Elected 3 years | 01.11.09 | | 31.10.12 | x | x | x | x | ✓ | ✓ |
| Mr Graham Avis | NHS Dorset | Appt'd 3 years | 01.11.10 | | 31.10.13 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Air Vice Marshal Geoffrey Carleton | Purbeck, East Dorset & Christchurch | Elected 3 years | 01.05. 09 | | 30.04.12 | ✓ | ✓ | ✓ | ✓ | ✓ | x |
| Mrs Emma Chamberlain | Poole | Elected 3 years | 01.11.09 | | 31.10.12 | ✓ | x | ✓ | ✓ | ✓ | ✓ |
| Ms Lynn Cherrett | Clinical staff | Elected 3 years | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | x | ✓ | ✓ | ✓ |
| Mr Andrew Creamer | Poole | Elected 3 years | 01.11.07 | 01.11.09 | 31.10.12 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mrs Vivien Duckenfield[2] | Poole | Elected 3 years | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | x | ✓ | ✓ | ✓ | ✓ |
| Ms Judith Geddes | Bournemouth Borough Council | Appt'd 3 years | 07.04.11 | | 06.01.14 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mrs Rosemary Gould | Purbeck, East Dorset & Christchurch | Elected 3 years | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mrs Jenny Jenkin | Bournemouth University | Appt'd 3 years | 01.11.10 | | 31.10.13 | ✓ | ✓ | x | ✓ | ✓ | ✓ |
| Mr David Jones | Dorset County Council | Appt'd 3 years | 01.07.10 | | 30.06.13 | ✓ | x | x | x | ✓ | x |
| Mr Richard King | Poole | Elected 3 years | 01.11.10 | | 31.10.13 | ✓ | x | ✓ | ✓ | x | ✓ |
| Miss Kris Knudsen | Clinical staff | Elected 3 years | 01.11.09 | | 31.10.12 | ✓ | ✓ | ✓ | ✓ | x | ✓ |
| Canon Jane LLoyd | Non-clinical staff | Elected 3 years | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mrs Isabel McLellan | N Dorset, W Dorset, Weymouth & Portland | Elected 3 years | 01.05.09 | | 30.04.12 | ✓ | x | x | ✓ | ✓ | ✓ |
| Mr Brian Newman | Bournemouth | Elected 3 years | 01.11.09 | | 31.10.12 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mrs Sue Power | Clinical Staff | Elected 3 years | 01.11.09 | | 31.10.12 | ✓ | ✓ | ✓ | ✓ | x | ✓ |
| Mr James Pride[3] | Poole | Elected 3 years | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Mrs Elizabeth Purcell | Poole | Elected 3 years | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| Mr Terence Purnell | Bournemouth | Elected 3 years | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mr Gerald Rigler | Poole | Elected 3 years | 01.11.09 | | 31.10.12 | X | ✓ | X | ✓ | ✓ | ✓ |
| Mr Glyn Smith | NHS Bournemouth & Poole | Appt'd 3 years | 01.11.07 | 01.11.10 | 31.10.13 | X | ✓ | ✓ | ✓ | ✓ | X |
| Mrs Ann Stribley | Poole Borough Council | Appt'd 3 years | 27.06.11 | | 26.06.14 | | | ✓ | ✓ | ✓ | ✓ |
| Mr Michael Wilkins | Poole Borough Council | Appt'd 3 years | 01/08/09 | | 26.06.11 | x | X | | | | |
| Mrs Sandra Yeoman | Poole | Elected 3 years | 01.11.09 | | 31.10.12 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | | | | | | | | | | | |
| No. public governors attending | | | | | | 12 | 9 | 11 | 13 | 13 | 12 |
| No. appointed governors attending | | | | | | 4 | 4 | 4 | 5 | 6 | 4 |
| No. staff governors attending | | | | | | 4 | 4 | 3 | 4 | 2 | 4 |

* Special meeting
[1] Annual members meeting followed the council of governors meeting
[2] Lead governor
[3] Deputy chairman

## BOARD MEMBER ATTENDANCE AT THE COUNCIL OF GOVERNORS 2011 - 2012

| | 7 April 2011 | 10 May 2011* | 7 July 2011 | 11 August 2011* | 6 October 2011 | 5 January 2012 |
|---|---|---|---|---|---|---|
| Chris Bown<br>Chief Executive | ✓ | x | x | x | ✓ | ✓ |
| Gareth Corser<br>Director of Strategy and Business Development | | | | x | ✓ | ✓ |
| Elizabeth Hall<br>Non-Executive Director | x | x | | | | |
| Jean Lang<br>Non-Executive Director | x | x | x | x | x | x |
| Ian Marshall<br>Non-Executive Director | ✓ | x | x | x | x | x |
| Michael Mitchell<br>Non-Executive Director | ✓ | x | x | x | x | x |
| Dame Yvonne Moores<br>Non-Executive Director/ Vice Chairman | ✓[1] | ✓[1] | x | x | ✓ | ✓ |
| Angela Schofield<br>Chairman | | | ✓ | ✓ | ✓ | ✓ |
| Mary Sherry<br>Chief Operating Officer | ✓ | x | ✓ | x | x | x |
| Martin Smits<br>Director of Nursing and Patient Services | ✓ | x | ✓ | x | ✓ | ✓ |
| Guy Spencer<br>Non-Executive Director/ Senior Independent Director | ✓ | ✓ | ✓ | x | ✓ | ✓ |
| Robert Talbot<br>Medical Director | x | x | x | x | x | x |
| Paul Turner<br>Director of Finance | ✓ | x | ✓ | x | ✓ | ✓ |
| Nick Ziebland<br>Non-Executive Director | | | x | x | x | x |

***** Extraordinary Meeting
[1] Chaired the meeting as Interim Chairman

### Nominations, remunerations and evaluation committee

The council of governors is required to establish a committee consisting of all or some of its members to assist in carrying out the specified functions relating to the appointment of the chair and non-executive directors; the review of the structure, composition and performance of the board; and the remuneration of the chairman and non-executive directors. The committee is chaired by the trust chairman, and comprises two public members, one nominated member, and one staff member. Members during 2011/12 were:

- Kris Knudsen (elected clinical staff governor)
- James Pride (elected governor for Poole constituency)
- Elizabeth Purcell (elected governor for Poole constituency)
- Jenny Jenkin (appointed governor for Bournemouth University) – from 7 July 2011

The committee met six times during the course of the 12 month period:

On 7 April 2011 the committee considered:
- The governance cycle for the committee
- The collective performance of the Council of Governors
- The process for the Chairman and Non-Executive Director's annual appraisal
- The annual report on the work of the committee

On 14 April 2011 the committee considered:
- The possible nominations for the substantive trust chairman

On 26 April 2011 the committee considered:
- The feedback from the chairman candidates presentation session
- The nomination of a substantive trust chairman

(The meetings held in April 2010 were supported with informal sessions with regards to the appointment of the substantive chairman).

On 7 July 2011 the committee considered:
- The process for the council of governors evaluation;
- The chairman's and non-executive directors' remuneration and allowances;
- The outcome of the chairman's performance review for 2010/11;
- The outcome of the non-executive directors' performance review for 2010/11;

On the 11 August 2011 the committee considered:
- The nomination for appointment of a new non-executive director

On 5 January 2011 (partly electronically facilitated) the committee considered:
- The outline process for the designate board of directors supporting the possible merger.

On the recommendation of the nominations, remuneration and evaluation committee, the council of governors approved:

- The appointment of Angela Schofield as chairman
- The appointment of Nick Ziebland as non-executive director
- The approval of the statement on the composition of the non-executive directors
- The chairman and non-executive director performance evaluation process
- The council of governors evaluation process
- The chairman's and non-executive directors' remuneration and allowances.

## NOMINATIONS, REMUNERATION & EVALUATIONS COMMITTEE ATTENDANCE 2011 - 2012

* Elected to Committee July 2011

| Name | Constituency | Type of Membership | Meetings | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 7 April 2011 | 14 April 2011 | 26 April 2011 | 7 July 2011 | 11 August 2011 | 5 January 2011 |
| Angela Schofield | Chairman | | | | | ✓ | ✓ | ✓ |
| Dame Yvonne Moores | (Interim Chair) | | ✓ | | | | | |
| Guy Spencer | SID | | ✓ | ✓[1] | ✓[1] | | | |
| Jenny Jenkin* | Bournemouth University | Appointed 3 years | | | | X | ✓ | ✓ |
| Kris Knudsen | Clinical staff | Elected 3 years | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Jamie Pride | Poole | Elected 3 years | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Elizabeth Purcell | Poole | Elected 3 years | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

[1] The Senior Independent Director chaired the meetings as Non-Executive Director Lead for the appointment of the new substantive Chairman

### Membership

Poole Hospital NHS Foundation Trust has four public constituencies and one staff constituency.

The four public constituencies are based on geographical areas that reflect our general, emergency and specialist service catchment areas; local government boundaries; and population numbers. They are:

- Poole
- Purbeck, East Dorset and Christchurch
- Bournemouth
- North Dorset, West Dorset, Weymouth and Portland

The staff constituency is divided into two groups: clinical and non-clinical.

Anyone aged 12 and over who lives in Dorset and is not employed by Poole Hospital can become a public member.

At 31 March 2012 the trust had 5,874 public members. The annual target for new members was 5% of the previous year's total which equated to 314 new members; the Trust achieved 309 new members for the year. Governors were still concerned that the additional costs of recruiting and managing a membership at the higher level would exacerbate the financial pressures faced by the trust.

There has been a decline in membership numbers as a result of the installation of a new membership database, which was allowed the database to be kept updated and regularly cleansed.

The staff and volunteer members total was 4,574. All staff and volunteers are members of the Trust automatically unless they choose to opt out.

The membership broadly reflects the populations the trust serves in terms of diversity. However, as may be expected given the demographics of the local area, the trust has proportionally slightly more members in the women and older age groups.

| **Membership by constituency and group** | |
|---|---|
| **Public constituency** | |
| Poole | 2,987 |
| Purbeck, East Dorset and Christchurch | 1,744 |
| Bournemouth | 878 |
| North Dorset, West Dorset and Weymouth and Portland | 265 |
| **Staff constituency** | |
| Clinical | 3,190 |
| Non-clinical (including volunteers) | 1,384 |

**Membership development strategy**

The main aim of the trust's membership development strategy is to:

- have a meaningful membership that is interested in the future of the Trust and is representative of the community we serve
- ensure that members have a say in helping us develop the future quality and type of services provided
- use our membership base to strengthen our links with the community and all stakeholders.

In line with the strategy, the major membership activity has concentrated on the following areas:

- Increasing governor participation in the recruitment and engagement of members
- Organising membership events to increase opportunities for membership engagement and participation
- Working to increase overall public membership number in line with agreed annual targets

Governors were invited to attend public events, including:

- Membership recruitment events and coffee mornings in local libraries
- Blandford Townswomen Guild
- Endoscopy unit open day
- Local GP practices
- Harry Paye Day
- Public consultation events for the proposed merger

The new membership engagement and recruitment reference group of the CoG had its inaugural meeting in May 2011 the group is chaired by a governor and is supported by the membership team. During the year the new group reviewed the strategy which was then approved by the board of directors and supported by the CoG. The group also refreshed the recruitment material for use by governors and agreed recruitment events to increase the public membership.

Recruitment and engagement events at libraries in the area and within different locations within the Trust were held during 2011/12. These were extremely successful in drawing new members to the hospital and engaging with differing age and ethnic groups.

The trust held its annual members' meeting on 6 October 2011. Members were invited via the membership newsletter, Foundation Talkback, and letters to individuals who expressed an interest in attending. The event was publicised in the local press, on our website and throughout the hospital. The event was well attended and Dr Ahmed, consultant anaesthetist in chronic pain provided a presentation on the pain management service within the hospital.

The staff governors continue to hold staff surgeries where staff members can approach them to express views on services and developments within the hospital. Staff governors also continue to have a regular slot in the induction programme for new members of staff.

Members may contact the CoG through the membership office by telephone 01202 448723, in writing, by email members.contact@poole.nhs.uk or via our website www.poole.nhs.uk.

These details are publicised in Foundation Talkback, our membership newsletter, on membership application forms and on our website.

## Code of governance compliance statement 2011/12

Monitor, the independent regulator of NHS foundation trusts, has produced a code of governance, which consists of a set of principles and provisions which may be viewed on Monitor's website: http://www.monitor-nhsft.gov.uk/sites/default/files/Code%20of%20Governance%20web-enabled%20version%20March%202010_0.pdf

Where a foundation trust does not meet the requirements of the code an explanation is required in the annual report.

The board consider that the trust has, during the last year of foundation trust status, applied the principles and partially met the requirements of the code. E.2.3 of the code states that the CoG should consult external professional advisers to market-test the remuneration levels of the chairman and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive, the Trust has frozen the remuneration for the chairman and non-executive director for the past two years so records a partial compliance for this element.

The trust's approach to the application of the main and supporting principles of the code is described throughout the body of this report.

# Quality report 2011/12

## CONTENTS



## PART 1 - CHIEF EXECUTIVE'S STATEMENT

Poole Hospital includes a quality report within the annual report for the fourth year running. The reason for doing this is to help our patients, public and stakeholders understand how well Poole Hospital is meeting their expectations for high quality healthcare. This is something which the Board of Directors at Poole Hospital wholeheartedly supports because the quality of care is our top priority and for which we should be held to account.

The Quality Report looks at how well Poole Hospital performed against key priorities for patient safety, clinical effectiveness and patient experience. Last year was one of excellent achievement against quality standards despite the financial challenges that the Trust faced. We were particularly pleased to receive a very positive endorsement from patients reporting on their experience of the Trust during the year.

The Board of Directors has continued its commitment to quality and patient safety with the establishment of a Quality, Safety and Performance Committee reporting to the Board of Directors and chaired by the vice chairman. The Board is proud of what staff have achieved in maintaining the highest standards in the fundamentals of care particularly in preventing pressure ulcers, stopping falls and preventing infections.

Further evidence of our commitment to patient safety was provided by the National Patient Safety Agency. Each year the NPSA publish data showing that staff at Poole Hospital are

encouraged to report incidents posing a threat to patient safety so that we may learn lessons and reduce risk. It is reassuring to note that 98 per cent of all reported incidents resulted in no or low harm to patients compared with a national average of 94 per cent (for similar Trusts).

It is a testament to all our staff and their hard work that 94% of inpatients and 97% of outpatients rated their care as good, very good or excellent in the national patient surveys last year. This is due to an ongoing commitment to continually reflect on and improve services largely through formal 'practice development unit' accreditation and adhering to the 'Poole Approach' to deliver excellent patient-centred care and treatment with dignity and respect.

I am particularly proud of our achievement of the whole Trust being accredited as a Practice Development Unit by Bournemouth University following a rigorous assessment process. My thanks go to all our staff.

During the forthcoming year and in spite of the more challenging financial situation we will continue to place quality at the heart of what we do. We will build on the considerable achievements of last year by improving our performance on a range of issues you can read about in this report and focusing particularly on the quality of care delivered to patients.

I am pleased to confirm that to the best of my knowledge the information contained in this report is accurate.

**Chris Bown**
**Chief executive**

# PART 2 – PRIORITY FOR IMPROVEMENT

## 1. OVERVIEW

Improving the quality of care is at the centre of everything we do at Poole Hospital. The desire to drive up quality standards is clearly articulated in the Poole Approach, our unique philosophy of care, which states that we will provide: 'friendly professional, patient-centred care with dignity and respect for all'.

During 2011-2012, we made good progress against 5 key quality improvement measures. We fully achieved what we set out to achieve in last year's quality report in all key areas. Details of what we have achieved can be found later on in this report.

Alongside these quality improvements has been the improvement in measures of fundamental care in particular hospital acquired pressure ulcers, patient falls and acquired infections. In each of these three key indicators both the number of incidents has fallen and the harm done to patients has lessened. Clinical staff have worked really hard to achieve this significant improvement over the position in 2010-2011.

In infection prevention the improvements noted last year have been continued. It was disappointing to have an MRSA bacteraemia (blood infection) at the start of the year after many months without one but by the end of March 2012 the Trust had been 11 months without a further MRSA bacteraemia. It has been really encouraging that, during the year, we recorded the lowest number of acquired Clostridium difficile infections since records began. Whilst norovirus has continued across the community the Trust has been successful in controlling the outbreaks in hospital and maintained the position compared with last year.

We improved waiting times for our patients by meeting the 18 week target for referral to admission ahead of target and maintaining it throughout the year. While this is an important quality improvement for our patients, we do recognise that there is more work to be done, especially in getting people who have broken bones to theatre as speedily as possible. We also want to improve the treatment of stroke patients, by ensuring more are treated within our specialist stroke services.

The Trust maintained its registration as a healthcare provider with the Care Quality Commission. Throughout 2011-2012 the Trust has been registered, without conditions, to provide:-

- nursing care
- accommodation for persons who require nursing or personal care
- diagnostic and screening procedures
- treatment of disease, disorder and injury
- surgical procedures
- maternity and midwifery care
- personal care
- termination of pregnancies
- management of supply of blood and blood derived products
- assessment or medical treatment for persons detained under the Mental Health Act

The Care Quality Commission has risk assessed the Trust on a monthly basis for quality and safety and these assessments show a consistent pattern of achievement against patient safety and quality outcomes.

The Care Quality Commission undertook an unannounced inspection of the Trust in November 2011. The Trust was pleased to have its maternity services found fully compliant and compliance found in six other outcome areas. It was disappointing that inspectors found moderate concerns in one outcome area around record keeping in 4 out of 14 areas visited. An action plan to address this issue is nearing completion.

## 2. QUALITY IMPROVEMENTS IN 2011-2012

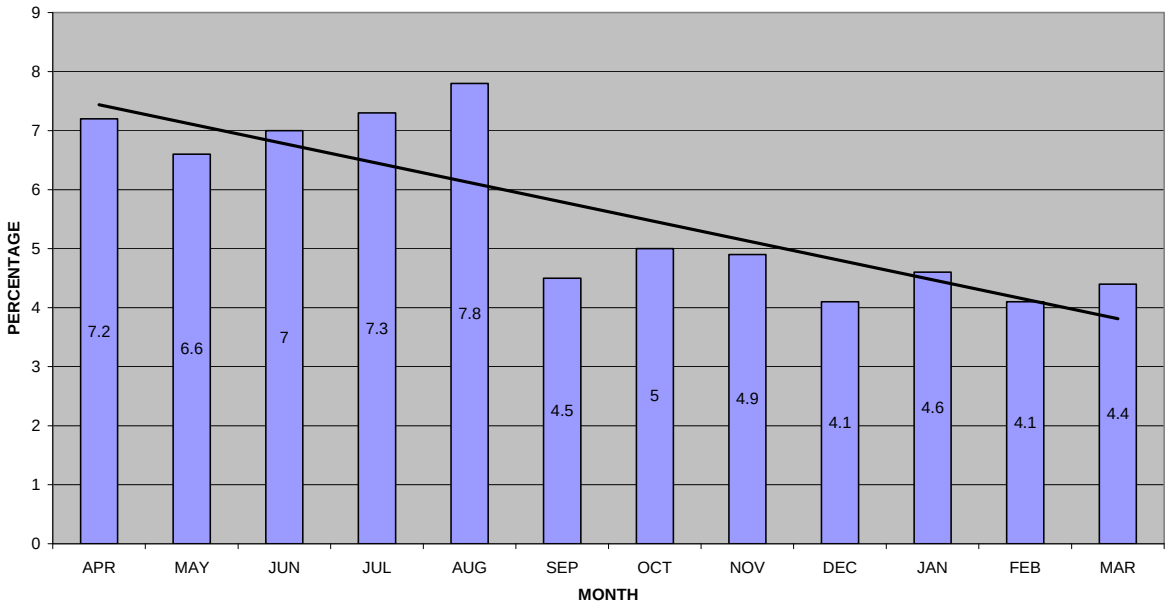
The Trust set out 5 quality improvements for 2011-2012 in its Quality Report for 2010-2011. The Trust has worked hard to achieve these improvements with considerable success the details are:-

### 2.1 Readmissions to the Trust

We set ourselves the target of reducing the number of unnecessary readmissions to the Trust, particularly in the first 30 days after treatment. Table 1 shows that the percentage has decreased during the year although it has fluctuated. Other data from Dr Foster shows that the Trust is below the national average and within expected ranges for readmissions.

## TABLE 1

**% OF PATIENTS READMITTED WITHIN ONE MONTH OF ORIGINAL ADMISSION (2011-2012)**



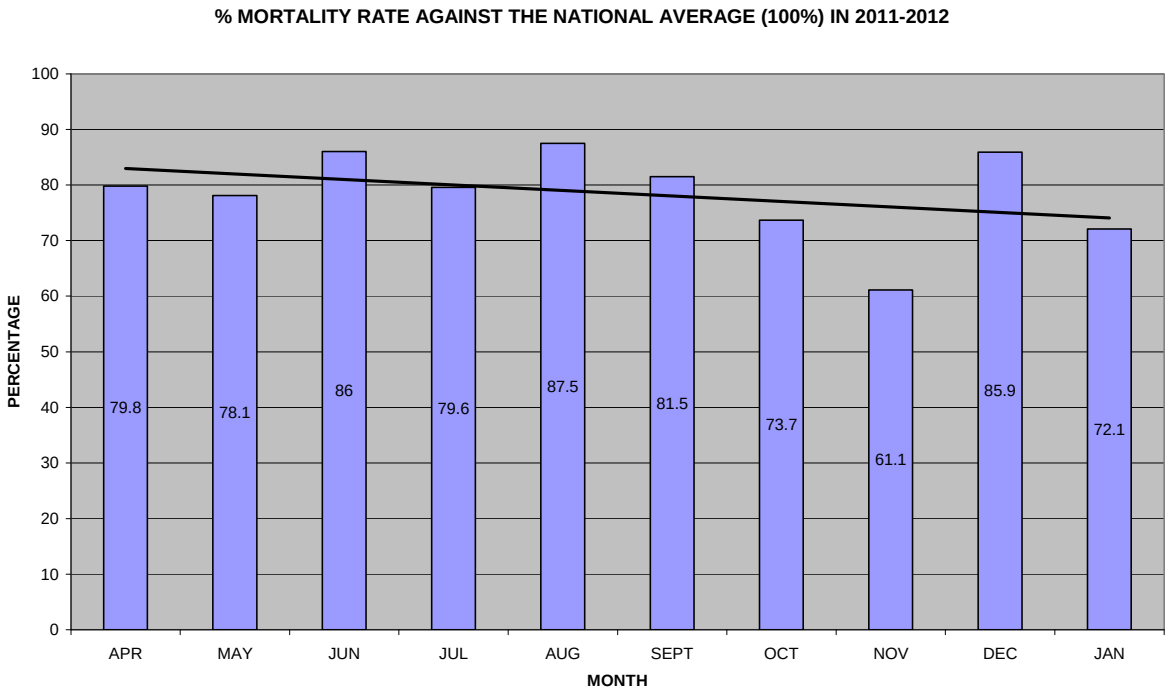

The straight line represents the trend in the data over the year.

Improvement target achieved.

## 2.2 Mortality

We set ourselves the target of understanding better why people die in hospital and reducing the overall mortality rates below the national mean. Table 2 shows the mortality rate of the Trust as a percentage rate compared to the national average of 100% during the 2011-2012.

## TABLE 2



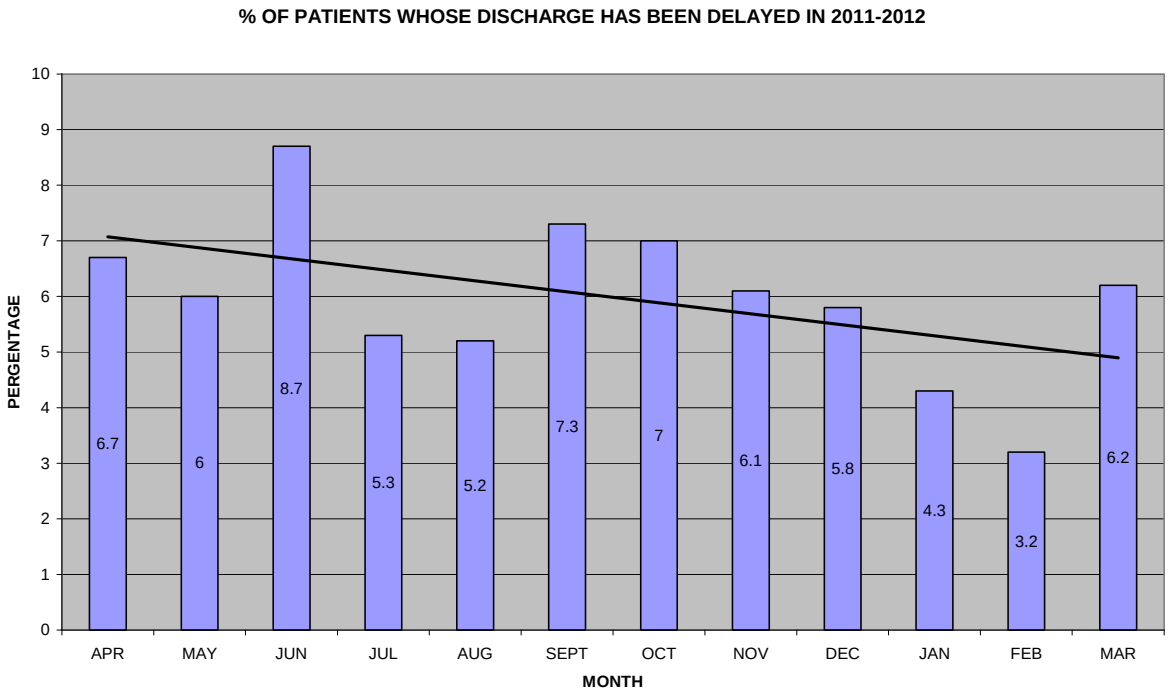

The straight line represents the trend in the data over the year.

Improvement target achieved.

## 2.3 Discharge from hospital

We set ourselves a target of reducing the number of patients whose discharge has been delayed and ensuring that people have the information they need on discharge so they do not need feel the need to complain. Table 3 shows the improvement that has been made in the delays to onward care. This improvement has been achieved through very good partnership working with other agencies.

## TABLE 3



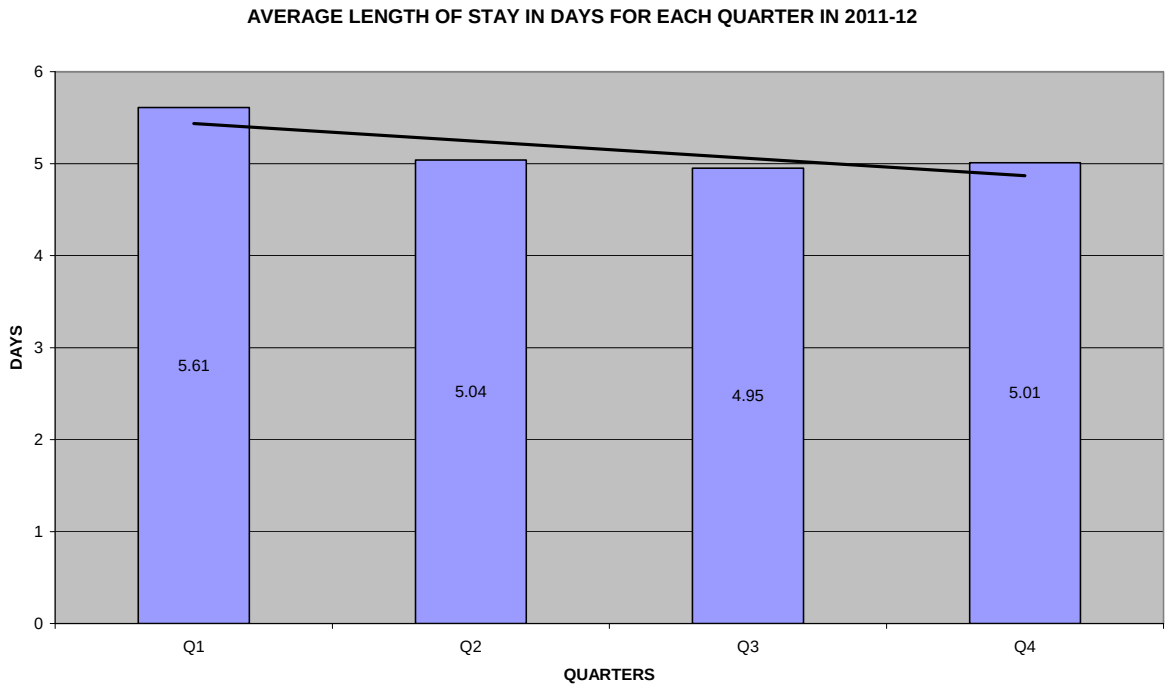

The straight line represents the trend in the data over the year.

Improvement target achieved.

## 2.4 Patient length of stay in hospital

We set ourselves the target of reducing the average length of stay of patients in Poole Hospital in each quarter of 2011-2012. Table 4 shows that the average length of stay (in days) for each quarter of 2011-2012. There was a decrease in length of stay in the first three quarters of the year but a marginal increase in the last quarter.

## TABLE 4




The straight line represents the trend in the data over the year.

Improvement target achieved.

### 2.5 Patient Experience of Children's Services and Cancer Services

We set ourselves the target of listening to the feedback from patients in paediatrics and cancer services and using comments made to improve the services in both areas.

We have used the comments provided by users of these two services to:-

- Improve kitchen facilities in the inpatient children's wards
- Create a more comprehensive paediatric assessment area open 24 hours a day
- Redesign of some patient leaflets in cancer services.

Improvement target achieved.

## 3. QUALITY IMPROVEMENTS FOR THIS COMING YEAR

The Board of Directors considers issues relating to patient care and safety, quality and clinical performance in detail at the meetings of its Quality, Safety and Performance Committee and during the public part of each and every monthly Board meeting.

In reviewing patient care, patient safety, clinical effectiveness and patient experience the board has targeted five key areas for improvement in this year (April 2012-March 2013). In selecting the areas for this year's quality improvements the Board has sought the views of patients, the public and staff through the Council of Governors. The Council of Governors set up a task group to advise the Trust on which areas should be targets for quality improvements in 2012-2013.

The Board in consultation with the Council of Governors has deliberately continued to target 2 areas from the improvements in 2011-2012 to ensure that the improvement continues and remains a top priority.

The areas for improvement in 2012-2013 are:-

### 3.1 Readmissions to the Trust

- Reducing the number of unnecessary readmissions to the Trust, particularly in the first 30 days after treatment.

### 3.2 Increase the right patient in the right place at the right time

- Increasing the number of patients placed in the specialist area they require and reducing the number of patients outlying in other wards.

### 3.3 Discharge from hospital

- Reducing the number of patients whose discharge has been delayed and ensuring that people have the information they need on discharge so they do not need feel the need to complain.

### 3.4 Accident and Emergency

- Increasing the percentage of people who are seen and treated within 4 hours in the Emergency Department of Poole Hospital in 2012-2013.

### 3.5 Post surgery infections

- Reducing the number of infections that patients acquired following surgery.

## 4. THE DETAILS OF OUR QUALITY IMPROVEMENTS FOR 2012-2013

### 4.1 PRIORITY 1

This priority for quality improvement is about reducing the number of patients who are readmitted to Poole Hospital within 30 days of an inpatient discharge.

### 4.1.1 Description of the Issue

- Around 4.5% (average in last six months of 2011-2012) of patients who have a spell of inpatient care are readmitted within 30 days. Some of these patients' readmission is unavoidable but in some cases the readmission could be avoided

### 4.1.2 Aim

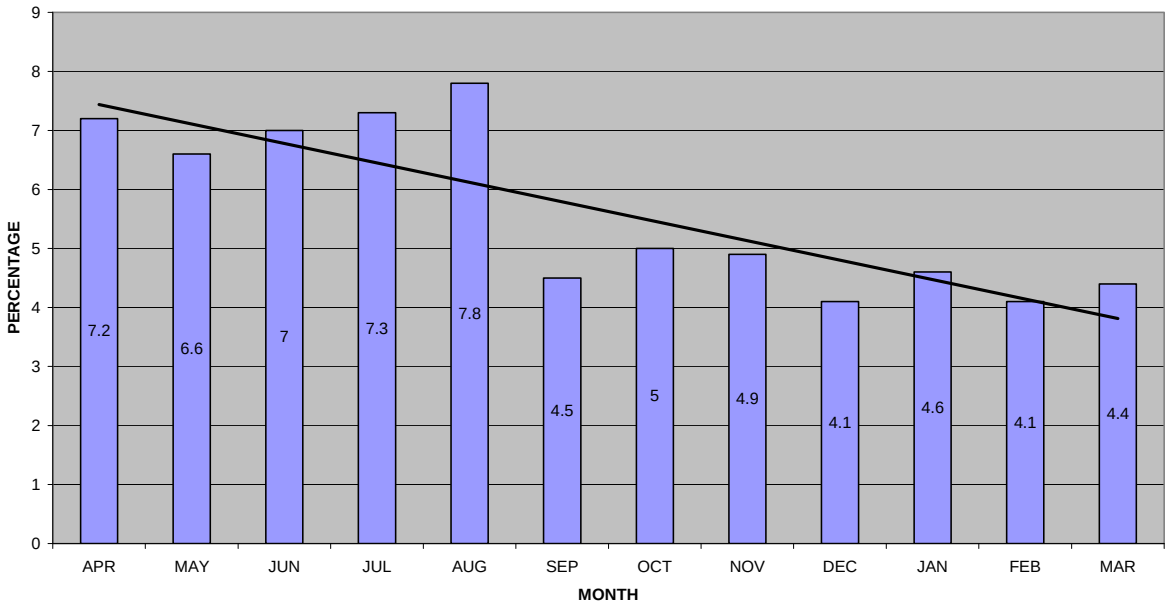
- To reduce the percentage of patients readmitted to hospital during 2012-2013 compared to the percentage readmitted in 2011-2012 using percentage readmission data

### 4.1.3 Current Position

- The current position for readmissions is detailed in the table below. This table shows the percentage of patients readmitted to Poole Hospital following an inpatient stay and discharge in 2011-2012

### TABLE 5

**% OF PATIENTS READMITTED WITHIN ONE MONTH OF ORIGINAL ADMISSION (2011-2012)**




Notes:- this data is derived from the readmissions up to 30 days after discharge and is therefore more than thirty days in arrears
The straight line represents the trend in the data over the previous year.

### 4.1.4 Actions to Deliver this Improvement

There are 3 key actions:-

1. Analyse the readmission data for inpatients identifying potential areas for improvement;
2. Establish implementation programmes for readmissions reduction in each clinical directorate
3. Implement action to reduce admissions.

### 4.1.5 Measurement, Monitoring and Reporting

All readmitted patients will be recorded on the hospital data system. Figures drawn from this database will be reported to the Board of Directors monthly and specifically the percentage of readmitted inpatients. Further detailed audit data will be published in the Trust

Board Sponsor: Chief Operating Officer
Implementation Leads: Clinical Directors and Matrons/Heads of Service

## 4.2 PRIORITY 2

This priority is about making sure that patients when admitted as an inpatient are placed on the right ward.

### 4.2.1 Description of Issue

- The Trust seeks to place patients in a ward whose specialty matches their medical diagnosis. This ensures that the right expertise is available

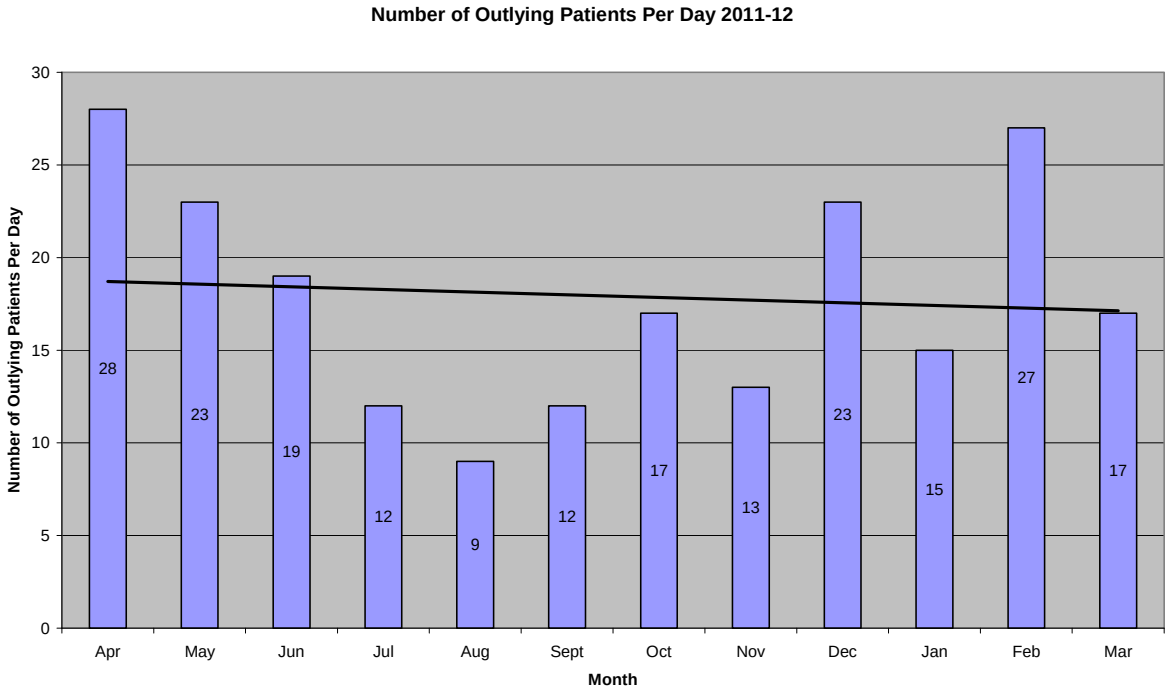
### 4.2.2 Aim

- To reduce the number of patients “outlying” in inappropriate wards.

### 4.2.3 Current Position

- The number of outlying patients on average each day per month is shown in Table 6.

## TABLE 6




**Note:** The straight line represents the trend in the data over the year.

### 4.2.4 Actions to Deliver this Improvement

1. Detailed analysis of patient data
2. Clinical group meetings to review data
3. Action planning to improve right patient, right ward.

### 4.2.5 Measurement, Monitoring and Reporting

All inpatient patient placement data is recorded by the Trust. The latest available data will be reported on a monthly basis as part of the clinical indicator report and scrutinised by the Quality, Safety and Performance Committee.

Board Sponsor: Chief Operating Officer

Implementation Leads: Clinical Directors, Matrons and Clinical Management Team

## 4.3 PRIORITY 3

This priority for quality improvement is about ensuring that people leave the hospital after an episode of inpatient care as soon as they are ready to be discharged or transferred. It is also about ensuring people have the right information as they leave.

### 4.3.1 Description of Issue

- The Trust has a target of just 3.5% of transfers being delayed for whatever reason. The Trust only achieved that performance level in one month of last year and as a result too many people are waiting in hospital unnecessarily for the next step in their onward care. Delays may occur for a variety of reasons for example a wait for transfer to another hospital or a wait for funding or a wait for family decision making.

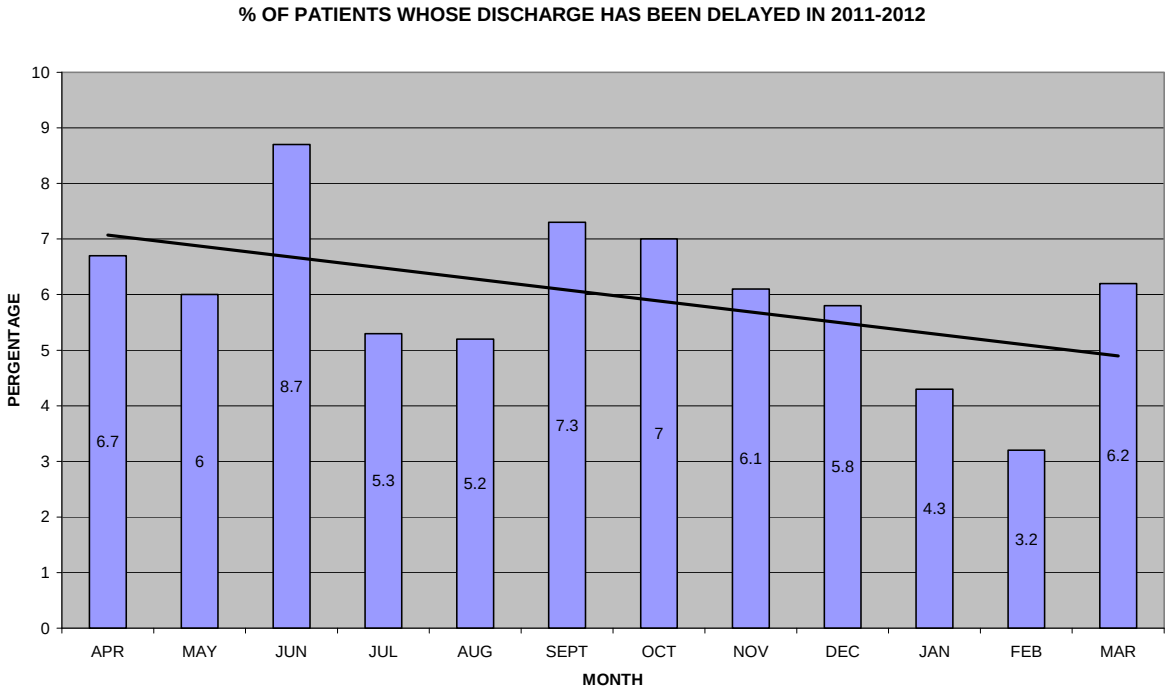
### 4.3.2 Aim

- To ensure that the percentage of patients whose onward care (discharge or transfer) is delayed reduces from the level at the end of March 2012. To improve the patient's experience of discharge as reported in the national patient survey

### 4.3.3 Current Position

- The table below shows the percentage of patients whose transfer has been delayed during 2011-2012

## TABLE 7




**Note:** The straight line represents the trend in the data over the year.

### 4.3.4 Actions to Deliver this Improvement

1. Patient care pathway management in the hospital
2. Interagency working led by Trust to achieve pathway compliance
3. Action plan on patient communication
4. Performance monitoring

### 4.3.5 Measurement, Monitoring and Reporting

All inpatient delayed transfers will be recorded through the Trust database. The latest available data will be reported on a monthly basis as part of the integrated performance report and scrutinised by the Quality, Safety and Performance Committee.

Board Sponsor: Chief Operating Officer

Implementation Leads: Discharge Team, Matrons & Clinical Directors

## 4.4 PRIORITY 4

This priority for quality improvement is about meeting the 4 hour A&E target and increasing the percentage of people who are seen and treated within 4 hours in the Emergency Department.

### 4.4.1 Description of Issue

- The Trust provides a 24 hour, 365 day a year Emergency Department service which accommodates a very variable number of patients each day.

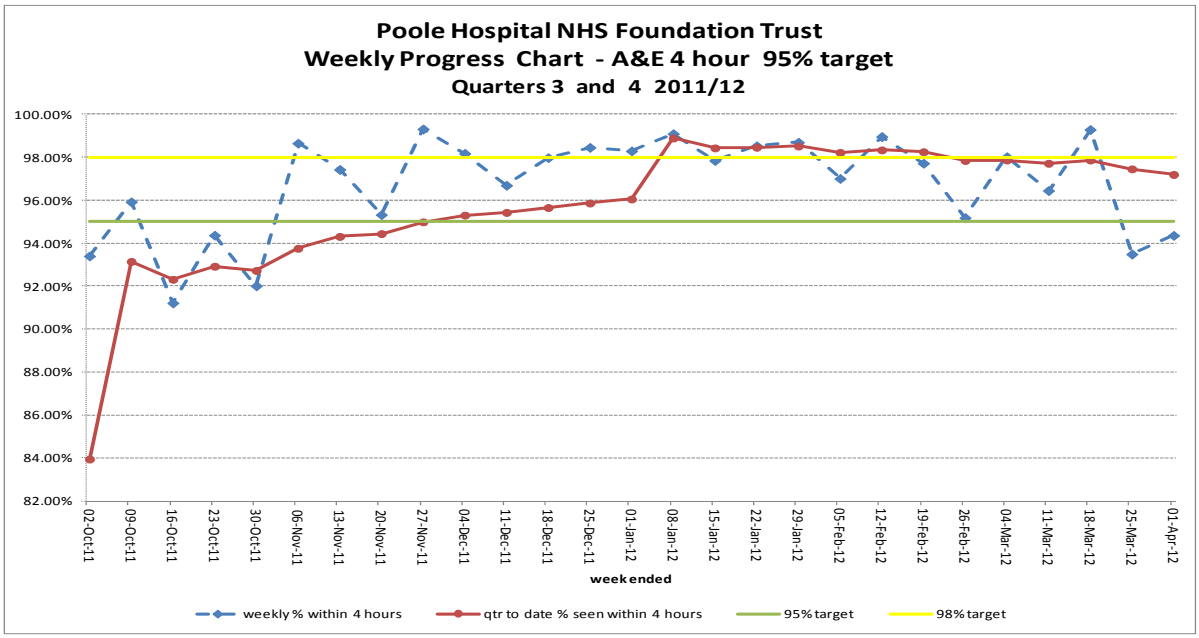
### 4.4.2 Aim

- To meet the A&E 4 hour target and increase the number of people who are seen and treated within 4 hours in the Emergency Department.

### 4.4.3 Current Position

- The Trust has worked hard to ensure that it consistently meets the 4 hour target for seeing and treating patients in the Emergency Department and is making progress as can be seen in the table below:-

## TABLE 8




### 4.4.4 Actions to Deliver this Improvement

1. Work on patient care pathways
2. Review of “bottlenecks”
3. Robust performance management

### 4.4.5 Measurement, Monitoring and Reporting

All Emergency Department patients are recorded on the electronic A&E data system. The system automatically collates and reports on the time for seeing and treating patients. Performance data will be recorded for patients and reported on a monthly basis as part of the integrated performance report to the Board of Directors and scrutinised by the Quality, Safety and Performance Committee.

Board Sponsor: Chief Operating Officer

Implementation Lead: Clinical Director and Matron/Business Manager

## 4.5 PRIORITY 5

This quality improvement priority focuses on patients post surgery in trauma and in obstetrics and targets reduction in post operative infections

### 4.5.1 Description of Issue

- There is a risk of infection following any surgery and the Trust is keen to do as much as possible to reduce that risk.

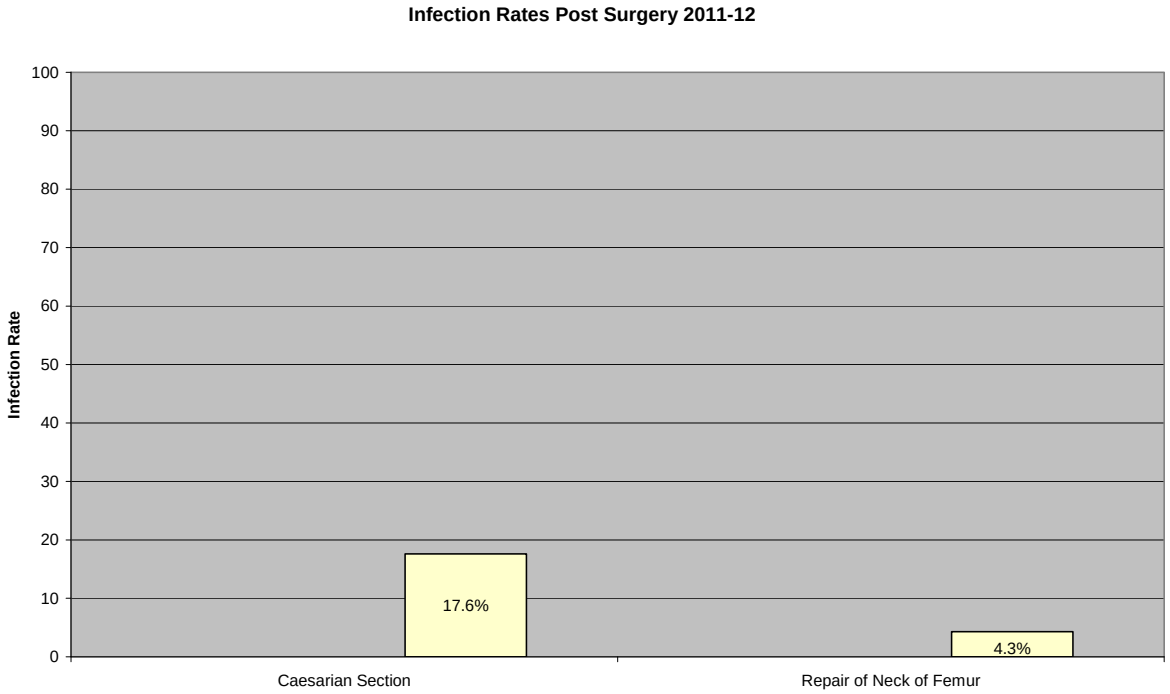
### 4.5.2 Aim

- Improve the infection rate post hip fracture surgery and Caesarean section.

### 4.5.3 Current Position

- The Trust monitors the infection rates in these two procedures through audits. The latest audits are produced in Table 11. The Trust will be collecting monthly audit data through 2012-2013.

## TABLE 9




### 4.5.5 Actions to Deliver this Improvement

1. Working group and regular audit review
2. Action planning following feedback
3. Robust infection prevention management

### 4.5.6 Measurement, Monitoring and Reporting

The infection rates will be scrutinised by the Infection Control Group and the Trust's Quality, Safety and Performance Committee

Board Sponsor: Director of Nursing and Patient Services

Implementation Leads: Clinical Directors and Matrons

## 5. STATEMENTS OF ASSURANCE FROM THE BOARD OF DIRECTORS

The Trust, as provider of health care services, is required to make a number of statements. The Trust has reviewed that data and has satisfied itself that it covers the three dimensions of patient experience, clinical effectiveness and patient safety accurately and correctly.

## 5.1 Provision of Clinical Services

- During 2011-2012, Poole Hospital NHS Foundation Trust provided a range of NHS services and did not sub contract any services.

- The Trust has reviewed all the data available to us on the quality of care of these NHS Services.

- The income generated by the NHS services reviewed in 2011-2012 represents 100 per cent of the total income generated from the provision of these services.

## 5.2 Clinical Audits

- During 2011-2012 43 national clinical audits and 2 national confidential enquiries covered NHS services that Poole Hospital NHS Foundation Trust provides.

- During that period Poole Hospital NHS Foundation Trust participated in 95% of national clinical audits and in 100% of national confidential enquiries of which it was eligible to participate in.

- The national clinical audits and national confidential enquiries that Poole Hospital NHS Foundation Trust was eligible to participate in and did participate in during 2011-2012 are listed below.

### TABLE 10 National Clinical Audits & National Confidential Enquiries

| **Eligible and participated** | |
|---|---|
| 1 | Perinatal mortality |
| 2 | Neonatal intensive and special care (NNAP) |
| 3 | Paediatric pneumonia |
| 4 | Paediatric asthma |
| 5 | Pain management |
| 6 | Childhood epilepsy (RCPH National Childhood Epilepsy Audit) |
| 7 | Diabetes (RCPH National Paediatric Diabetes Audit) |
| 8 | Emergency use of oxygen |
| 9 | Adult community acquired pneumonia |
| 10 | Non-invasive ventilation - adults |
| 11 | Cardiac arrest (National Cardiac Arrest Audit) |
| 12 | Severe sepsis & septic shock |
| 13 | Adult critical care (ICNARC CMPD) |
| 14 | Potential donor audit (NHS Blood & Transplant) |
| 15 | Seizure management (National Audit of Seizure Management) |
| 16 | Diabetes (National Adult Diabetes Audit) |
| 17 | Heavy menstrual bleeding (RCOG National Audit of HMB) |
| 1 | Chronic pain (National Pain Audit) |

| | |
|---|---|
| 8 | |
| 19 | Ulcerative colitis & Crohn's disease (UK IBD Audit) |
| 20 | Parkinson's disease (National Parkinson's Audit) |
| 21 | COPD |
| 22 | Adult asthma |
| 23 | Bronchiectasis |
| 24 | Hip, knee and ankle replacements (National Joint Registry) |
| 25 | Elective surgery (National PROMs Programme) |
| 26 | Acute Myocardial Infarction & other ACS (MINAP) |
| 27 | Heart failure (Heart Failure Audit) |
| 28 | Acute stroke (SINAP) |
| 29 | Cardiac arrhythmia (Cardiac Rhythm Management Audit) |
| 30 | Lung cancer (National Lung Cancer Audit) |
| 31 | Bowel cancer (National Bowel Cancer Audit Programme) |
| 32 | Head & neck cancer (DAHNO) |
| 33 | Oesophago-gastric cancer (National O-G Cancer Audit) |
| 34 | Hip fracture (National Hip Fracture Database) |
| 35 | Severe trauma (Trauma Audit & Research Network) |
| 36 | Falls and non-hip fractures (National Falls & Bone Health Audit) |
| 37 | Bedside transfusion (National Comparative Audit of Blood Transfusion) |
| 38 | Medical use of blood (National Comparative Audit of Blood Transfusion) |
| 39 | Care of dying in hospital (NCDAH) |
| 40 | Dementia |
| 41 | Continence care |
| **Eligible and did not participate** | |
| 42 | Risk factors (National Health Promotion in Hospitals Audit) |
| 43 | Pleural procedures |

- The national clinical audits and national confidential enquiries that Poole Hospital NHS Foundation Trust participated in, for which data collection was completed during 2011-2012, 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.

## TABLE 11 Participation Rates in National Clinical Audits

| Eligible and participated | | Data collection completed in 2011/12 | % Cases Submitted | Comments |
|---|---|---|---|---|
| 1 | Perinatal mortality | Yes | Not appropriate to calculate participation rates due to nature of the project. | |
| 2 | Neonatal intensive and special care (NNAP) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 3 | Paediatric pneumonia | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 4 | Paediatric asthma | Yes | 100% | |
| 5 | Pain management | Yes | 100% | |
| 6 | Childhood epilepsy (RCPH National Childhood Epilepsy Audit) | Yes | 100% | |
| 7 | Diabetes (RCPH National Paediatric Diabetes Audit) | Yes | 100% | |
| 8 | Emergency use of oxygen | Yes | 7 wards | The minimum cohort for this project was one ward. |
| 9 | Adult community acquired pneumonia | Yes | 100% | |
| 10 | Non-invasive ventilation - adults | Yes | 0% | Data submitted but not “committed” so did not form part of formal analysis. |
| 11 | Cardiac arrest (National Cardiac Arrest Audit) | Yes | Not appropriate to calculate participation rates due to nature of the project. | |
| 12 | Severe sepsis & septic shock | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 13 | Adult critical care (ICNARC CMPD) | Yes | Not appropriate to calculate participation rates due to nature of the project. | |
| 14 | Potential donor audit (NHS Blood & Transplant) | Yes | Not appropriate to calculate participation rates due to nature of the project. | |
| 15 | Seizure management (National Audit of Seizure Management) | Yes | 100% | |
| 16 | Diabetes (National Adult Diabetes Audit) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 17 | Heavy menstrual bleeding (RCOG National Audit of HMB) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 18 | Chronic pain (National Pain Audit) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 19 | Ulcerative colitis & Crohn’s disease (UK IBD Audit) | Yes | 100% | |
| 20 | Parkinson’s disease (National Parkinson’s Audit) | Yes | 100% | |
| 21 | COPD | Yes | 57% | Due to clinical commitments unable to submit all required cases. |
| 22 | Adult asthma | Yes | 100% | |
| 23 | Bronchiectasis | Yes | 85% | |

| | | | | |
|---|---|---|---|---|
| 24 | Hip, knee and ankle replacements (National Joint Registry) | Yes | Site specific data not available. | |
| 25 | Elective surgery (National PROMs Programme) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 26 | Acute Myocardial Infarction & other ACS (MINAP) | Yes | 100% | |
| 27 | Heart failure (Heart Failure Audit) | Yes | 100% | |
| 28 | Acute stroke (SINAP) | Yes | 10 cases per month submitted, meeting the agreed minimum requirements. | |
| 29 | Cardiac arrhythmia (Cardiac Rhythm Management Audit) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 30 | Lung cancer (National Lung Cancer Audit) | Yes | 93% | |
| 31 | Bowel cancer (National Bowel Cancer Audit Programme) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 32 | Head & neck cancer (DAHNO) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 33 | Oesophago-gastric cancer (National O-G Cancer Audit) | No | Not applicable | Deadline for data submission October 2012. |
| 34 | Hip fracture (National Hip Fracture Database) | Yes | 94% | |
| 35 | Severe trauma (Trauma Audit & Research Network) | Yes | 10%* | *10% reported based on HES data. The ED consultants consider that all required cases have been submitted. |
| 36 | Falls and non-hip fractures (National Falls & Bone Health Audit) | No | Not applicable | Data collection completed 2010/11 (included from report perspective). |
| 37 | Bedside transfusion (National Comparative Audit of Blood Transfusion) | No | Not applicable | Data collection completed 2010/11 (included from report perspective). |
| 38 | Medical use of blood (National Comparative Audit of Blood Transfusion) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 39 | Care of dying in hospital (NCDAH) | Yes | 100% | |
| 40 | Dementia | No | Listed on 2011/12 NCAPOP programme but data collection due to commence April 2012. | |
| 41 | Continence care | No | Listed on 2011/12 NCAPOP programme with pilot stage completed late in 2011/12 and feedback being requested in 2012/13. | |

- The reports of 36 national clinical audits were reviewed by the provider in 2011/12 and Poole Hospital intends to take the following actions to improve the quality of healthcare provided.

## TABLE 12 National Clinical Audits Reviewed in 2011-2012 and Local Action Plans

| No | Title | Actions being taken |
|---|---|---|
| 1 | NHS Blood and Transplant: Potential Donor Audit (1st April 2010 to 31st March 2011) | No local action plan required |
| 2 | The National Hip Fracture Database: National Report 2011 (1st April 2010 to 31st March 2011) | Within the Trust, the Trauma Improvement Group meet fortnightly and as part of their remit, the results from this national audit are reviewed and action taken as appropriate. From the Trauma Improvement Group's review of the results from the current round of this national project, no specific areas for action / change in practice were identified that were in addition to their current programme of quality improvement work for patient care within Trauma. |
| 3 | Feverish Children National Audit (1st August 2010 to 31st January 2011) | 1. E-learning module to be encouraged following induction<br>2. Adaptation of Symphony System to ensure data collection complete<br>3. Improve availability of Traffic Light System |
| 4 | National Diabetes Inpatient Audit (NaDIA) (1st November 2010 to 12th November 2010) | 1. Introduce new insulin chart immediately<br>2. Undertake a specific audit looking at the incidence of insulin prescription errors<br>3. To undertake a project which looks to improve foot examinations on diabetic patients |
| 5 | National Sentinel Stroke Audit (1st April 2010 to 30th June 2010) | 1. To increase capacity on stroke unit<br>2. To increase medical nursing and therapy staffing on stroke unit<br>3. To develop early supported discharge team to decrease length of stay<br>4. To undertake CT scanning for stroke patients at weekends |
| 6 | National NCASP Diabetes Audit - Adults (1st September 2009 to 31st August 2010) | No local action plan required |
| 7 | British Thoracic Society (BTS) Emergency Oxygen Audit (15th August 2011 to 1st November 2011) | 1. To present findings of the audit to the Medical Clinical Governance meeting<br>2. To appoint an oxygen champion<br>3. Oxygen committee to produce new oxygen policy<br>4. Oxygen administration flow chart to be given to all junior doctors and placed by all oxygen points<br>5. To update the oxygen prescription section on drug chart |

| | | |
|---|---|---|
| 8 | National British Thoracic Society (BTS) Adult Asthma Audit (1st September 2011 to 31st October 2011) | 1. To present the audit findings to the Respiratory Department<br>2. Respiratory Nurse Specialist to visit medical admissions unit daily to find asthmatic patients<br>3. To improve documentation on inhaler technique<br>4. All patients to be discharged with Allen & Hanbury's peak flow diaries containing an action plan<br>5. To approach acute physicians to promote referral |
| 9 | National Care of the Dying Audit - Hospitals: 3rd Round (1st April 2011 to 30th June 2011) | 1. Review of the audit results by Poole Hospital End of Life (EoL) Group<br>2. To discuss with the Education Department any other opportunities for Liverpool Care Pathway (LCP) training for HCA's and possibility of a mandatory element to end of life care training for healthcare workers in the Trust.<br>3. To review the local mouth care policy<br>4. To discuss with Cardiology the use of a "grab sheet" for turning off Implantable cardioverter defibrillator (ICD)'s<br>5. To review the Palliative Care intranet site re LCP content – education and information<br>6. To undertake a review of LCP Champions<br>7. To design an audit tool to enable feedback from relatives of patients on the LCP<br>8. To discuss within the EoL Group, the current practice for informing Primary Health Care Team (PHCT) of death within 24hrs and review |
| 10 | National Mastectomy and Breast Reconstruction Audit: 2011 Report (1st January 2008 to 31st March 2009) | 1. To discuss the audit findings at the Breast Network Site Specific Group (NSSG) meeting in September 2011<br>2. To amend the local patient satisfaction survey to include the questions for which Poole Hospital was found to be an outlier in the national audit<br>3. To update local patient information to incorporate the national data on complication rates |
| 11 | National Lung Cancer Audit: 2011 Annual Report (1st January 2010 to 31st December 2010) | No local action plan required |
| 12 | ICNARC: National Cardiac Arrest Audit (NCAA) (1st April 2011 to 31st December 2011) | No local action plan required |

| | | |
|---|---|---|
| 13 | National Elective Surgery Patient Reported Outcome Measures (PROMs) (1st April 2009 to 31st August 2010) | 1. To undertake a review of activity generated off-site but undertaken at Poole Hospital to ensure all patients pre-assessed for Groin Hernia Surgery in outlying healthcare providers are included in the PROMs process<br>2. To ensure that robust systems are in place in the outpatients department to administer the paperwork |
| 14 | National Comparative Audit of Blood Transfusion: Platelets (1st September 2010 to 31st December 2010) | 1. The Blood and Blood Products Policy to be updated next review period (2013) to be more prescriptive for threshold triggers for individual procedures<br>2. Laboratory standard operating procedure (SOP) for platelet issue to be updated to include specific procedures giving more guidance to lab staff on appropriate triggers to support them in challenging seemingly inappropriate requests for platelet donations. This requires the continual support from the haematology consultants working to local guidelines based on national BSCH standards<br>3. To raise awareness of the need for a post transfusion pre-procedure platelet count with both medical and laboratory staff<br>4. To discuss with all consultant haematologists the rationale for platelet transfusions above our local and national trigger of 10x10^9/l<br>5. To raise awareness with consultant haematologists of the need for pre-transfusion platelet counts for haematology patients<br>6. To improve documentation in the patient's medical notes of rational for platelet transfusion especially if the threshold is greater than the indicated transfusion trigger by increasing awareness of the importance of documentation of the rational at medical training<br>7. To continue good practice with regards to blood stock management and aim for further reductions in products wasted |
| 15 | National Joint Registry (NJR) | No local data provided in the national report |
| 16 | Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme (1st January 2010 to 31st March 2010) | 1. Work is ongoing with the Clinical Management Team in response to these audit findings<br>2. Review and discussion of outliers within the audit findings<br>3. Continued participation with the ICNARC project |

| | | |
|---|---|---|
| 17 | ICNARC: National Cardiac Arrest Audit (NCAA) (1st January 2010 to 30th June 2010) | No local action plan required |
| 18 | National Pleural Procedures Audit (1st June 2010 to 30th July 2010) | 1. To present at Clinical Governance meeting January 2011<br>2. To devise formal training for junior staff<br>3. To encourage training for Specialist Registrars in thoracic ultrasound |
| 19 | British Thoracic Society (BTS) Emergency Oxygen Audit (1st October 2010 to 15th November 2010) | 1. To present findings at Departmental meeting on 04/04/11<br>2. Trust oxygen use guidelines are to be re-written |
| 20 | National British Thoracic Society (BTS) Adult Asthma Audit (1st September 2010 to 31st October 2010) | 1. To present the findings at Departmental meeting on 04/04/11<br>2. To increase nursing time available for asthma patient review. New nurse commenced in post in June 2011 |
| 21 | National Audit of Bronchiectasis (1st October 2010 to 30th November 2010) | 1. Findings to be presented to consultant respiratory physicians<br>2. Key areas of concern to be circulated to consultants<br>3. Clinic stamps to be bought to help improve documentation<br>4. Re-audit with next national round |
| 22 | National Audit of Continence Care (NCAPOP) (1st January 2010 to 29th March 2010) | 1. To introduce Continence Assessment Tool to all wards<br>2. To review Link Nurse role<br>3. To introduce education programme for ward staff |
| 23 | National Audit of Dementia (Care in General Hospitals) (1st September 2009 to 28th February 2010) | 1. To maintain dignity and respect for all patients on Department of Medicine for the Elderly (DME) wards<br>2. To ensure the nutrition and hydration of all patients on DME wards are well met<br>3. To implement appropriate workplace development to enable DME staff to care for patients with dementia |
| 24 | National Bowel Cancer Audit: 2009 Annual Report (1st August 2007 to 31st July 2008) | Local results for this national project have been reviewed and reported locally. No action required. |
| 25 | National Care of the Dying Audit 2008 | 1. Implement version 12 of the LCP<br>2. Education and awareness of the new version of the LCP(12) |
| 26 | NHS Blood and Transplant: Potential Donor Audit (1st April 2010 to 30th | 1. Continue Potential Donor Audit and track instances of non-referral<br>2. Education and training across Critical Care and the Emergency Department |

| | | |
|---|---|---|
| | September 2010) | |
| 27 | National Neonatal Audit Programme (NNAP) (1st January 2009 to 31st December 2009) | No local action plan required. |
| 28 | BTS Paediatric Asthma 2010 | 1.To add three asthma specific criteria on discharge checklist |
| 29 | NCASP (National Clinical Audit Support Programme) Diabetes Audit - Children 1st September 2009 to 31st August 2010 | No local action plan required |
| 30 | National Maternal & Perinatal Mortality Surveillance (CMACE)(1st January 2009 to 31st December 2009) | It should be noted that for every stillbirth or neonatal death there is a full review and risk assessment undertaken. Individual cases are presented and reviewed at bi-monthly meetings, in order to determine whether the outcomes could have been avoided.<br><br>The current processes in place are evidenced as working well and therefore no changes in practice are required. Also, as cases are risk assessed individually, it would be inappropriate to undertake an overall risk assessment on this summary report. |
| 31 | Vital Signs National Audit (1st August 2010 to 31st January 2011) | To amend Symphony system and clinical practice |
| 32 | National Audit of Non Invasive Ventilation (Adults) (1st February 2011 to 31st March 2011) | 1. To present at departmental meeting<br>2. To participate in the next round of this national audit in 2012 |
| 33 | National Audit of Adult Community Acquired Pneumonia (1st December 2010 to 31st January 2011) | 1. To repeat audit when acute physicians in post on Medical Assessment Unit (MAU) |
| 34 | National Oesophago-gastric Cancer Audit (1st October 2007 to 30th June 2009) | No local action plan required |
| 35 | National Head and Neck Cancer Audit (DAHNO): 6th Annual Report (1st November 2009 to 31st October 2010) | No local action plan required |

| | | |
|---|---|---|
| 36 | National Lung Cancer Audit: 2010 Annual Report (1st January 2009 to 31st December 2009) | No local action plan required |

### TABLE 13 National Clinical Audit Reports Currently Being Reviewed by the Local Clinical Teams

| No | Title |
|---|---|
| 1 | National Audit of Bronchiectasis (1st October 2011 to 30th November 2011) |
| 2 | National Bowel Cancer Audit: 2011 Annual Report (1st August 2009 to 31st July 2010) |
| 3 | National Audit of Seizure Management in Hospitals |
| 4 | National Bowel Cancer Audit: 2010 Annual Report (1st August 2008 to 31st July 2009) |
| 5 | National Audit of the Organisation of Services for Falls & Bone Health for Older People (1st April 2010 to 31st July 2010) |
| 6 | National Neonatal Audit Programme (NNAP) (1st January 2010 to 31st December 2010) |
| 7 | Myocardial Infarction National Audit Project (MINAP) (1st April 2010 to 31st March 2011) |
| 8 | Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme (1st April 2010 to 31st March 2011) |

-The reports of 139 local clinical audits were reviewed by the provider in 2011/12 and Poole Hospital intends to take the following actions to improve the quality of healthcare provided:

23 identified that change in practice was not required due to good performance.

Of the remaining 116, Poole Hospital has undertaken the following actions to improve the quality of healthcare provided. The following are a number of examples:

### 5.2.1 - Develop new and improve existing patient information

- A pelvic radiotherapy patient information sheet has been revised for patients with squamous cell carcinoma of the anus

- Poster campaign undertaken to encourage patient's relatives / carers to encourage patients to drink

### 5.2.2 - Improve the education and training of new as well as existing staff

- Education sessions (one to one) undertaken regarding the use of block anaesthesia for patients with fractured neck of femur

- Teaching sessions provided for junior doctors (F1s) and middle grade doctors (SHO's) regarding the production of an inpatient discharge summary

- Education programme for GPs established regarding fast track referral of suspected melanoma patients

- Formal training has been devised and is now in place for the insertion of chest drains

- Working together with University Hospital Southampton NHS Foundation Trust (UHS) to examine undergraduate medical training in order to try and improve the standard of medical documentation

- Training on the use of the Malnutrition Universal Screening Tool (MUST) included on the nurse induction training programme

- Training on water swallow screening is now being offered to medics and stroke unit nurses

- Education and training is now being provided to midwives on the caring of patients in maternity recovery and the high dependency unit (HDU)

- Introduction of a 'Maternity Immediate Life Support Course' for midwives and obstetricians

- Training on MUST and oral nutrition support is being provided to F1 grade doctors

- Provision of teaching sessions to staff who are involved in venous thromboembolism (VTE) risk assessment as well as staff who interpret the risk assessment and prescribe prophylaxis

- Poster campaign implemented to increase information and awareness of VTE assessment

- Nurse induction training has been amended to include specific training on: grading pressure ulcers; pressure ulcer documentation requirements in care plans; and the reporting of pressure ulcers.

### 5.2.3 - Develop new and update existing local policy and guidance documents

- Development of guidelines on the production of an inpatient discharge summary. The guidelines are available on the intranet.

- Revised falls prevention and management tool (FallOut Plan) developed and implemented

- New Trust policy implemented for the treatment of severe sepsis and septic shock

- Site specific multidisciplinary (MDT) guidelines written for patients with primary brain tumours

- New guidelines produced for the Emergency Department for use of antibiotics in clinically non-infected non-bite wounds / lacerations / soft tissue Injuries

- Guidelines for the use of antithrombotic treatment after stroke and transient ischemic attack produced

### 5.2.4 - Develop new and improve existing local pro forma/charts/forms

- Consent forms are now pre-printed with the hospital name
- Drug charts now ask for the General Medical Council (GMC) number to be added allowing for identification of doctors
- National Patient Safety Agency (NPSA) flowchart to check nasogastric (NG) position available in the medical notes with the NG regime for reference. The flowchart is also available on the intranet
- Drop down drug allergy box added to the electronic patient record (EPR)
- Introduction of a form for the transportation of bone marrow from Main Theatres to the Blood Transfusion Department
- Introduction of a new observation chart that involves recording paediatric blood pressure as part of a scoring system to assess severity of illness
- Redesign of the surgical safety checklist for Maternity and Main Theatre
- New protocol in place within the Emergency Department to improve the documentation of the re-evaluation of pain
- Pre MUST screening questions have been removed from the MUST tool to encourage a full nutritional assessment to be undertaken for all adult inpatient admissions
- Documentation updated to improve the assessment of VTE risk as well as risk of bleeding
- Introduction of a new proforma in the Emergency Department to aid the management of adult patients presenting with a pneumothorax

### 5.2.5 - Updates to local clinical working practice

- Rapid infusion of intravenous cold crystalloids has been established in the Emergency Department for patients with ventricular fibrillation / ventricular tachycardia arrest
- An acute oncology service to promptly assess new or changing clinical needs in patients on systematic anticancer therapy (SACT) has been introduced
- Nutrition nurse appointed
- A mealtime companion initiative launched to recruit volunteers and staff to assist patients with eating and drinking
- Reassessments of patients at ‘high risk’ of deep vein thrombosis following Doppler ultrasound scan now undertaken by nurse practitioners
- New theatre practitioners have been employed with increased responsibilities for the care of patients in maternity recovery and HDU

- Local practice updated within the day case unit so that all day case patients are risk assessed for VTE as per the policy for inpatients

- Improvements have been made to the storage and timely access of replacement mattresses

- The supply of spare mattresses has been increased to ensure prompt replacement when a failure is identified

## 5.3 Clinical Research

- The number of patients receiving NHS services provided by Poole Hospital NHS Foundation Trust in 2011-2012 that were recruited during that period to participate in research approved by a research ethics committee was 882.

## 5.4 Goals agreed with Commissioners

- A proportion of Poole Hospital NHS Foundation Trust's income in 2011-2012 was conditional on achieving quality improvement and innovation goals agreed between the Trust and its Lead Commissioner, - NHS Bournemouth and Poole. NHS Bournemouth and Poole and Poole Hospital NHS Foundation Trust had a contract for the provision of NHS services that included a commissioning for quality and innovation payment framework (CQUIN). In 2011-2012 this was equivalent to £2.4 million which was paid to the Trust. Further details of the agreed goals for 2011-2012 and for the following twelve month period (2012-2013) are available on request from:-

  Director of Nursing and Patient Services,
  Poole Hospital NHS Foundation Trust,
  Longfleet Road,
  Poole,
  Dorset, BH15 2JB.

## 5.5 Registration with the Care Quality Commission

- Poole Hospital NHS Foundation Trust is required to register with the Care Quality Commission

- The Trust is registered unconditionally with the Care Quality Commission from 1 April 2010.

- The Care Quality Commission has not taken any enforcement action against Poole Hospital NHS Foundation Trust during 2011-2012.

- Poole Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC in the reporting period.

- Poole Hospital NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission and no reviews were undertaken in the period 1st April 2011 to 31st March 2012.

- The Trust had an unannounced inspection by the CQC in November 2011. Eight outcome areas were considered and the Trust was found to be compliant in seven areas and the CQC had a "moderate" concern in a further area. A detailed action plan

has been shared with the CQC and is being implemented to bring the Trust to full compliance.

### 5.6 Data Quality

- Poole Hospital NHS Foundation Trust submitted records during 2011-12 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics. The following data quality comparisons are from the latest published data from SUS for the eleven months to February 2012.

- The percentage of records submitted which included the patient's valid NHS number was (national averages are shown in brackets):

  99.4% (98.8%) for admitted care
  99.8% (99.0%) for outpatient care
  97.5% (93.3%) for accident and emergency care

- The percentage of records submitted data which included the patient's General Practitioner practice code was:

  100% (99.8%) for admitted care
  100% (99.7%) for outpatient care
  100% (99.4%) for accident and emergency care

- Poole Hospital NHS Foundation Trust's Information Governance Assessment Report overall score for 2011-2012 was 81% and was graded as green (satisfactory).

- Poole Hospital NHS Foundation Trust will be taking action in the areas of equipment support and the security of mobile devices to improve data quality through compliance with IG Toolkit Action Plan to obtain level 3 in all criteria.

- Poole Hospital NHS Foundation Trust was subject to a Payment by Results data assurance framework (clinical coding) audit this year undertaken by the Audit Commission. The Trust error rate of 3.0% represents a further improvement on the previous year of audit and can be compared with a national average of 9.1% in the last full year of audits across all providers.

## PART 3 – REVIEW OF QUALITY PERFORMANCE

### 6. WHAT PATIENTS AND THE PUBLIC HAVE SAID

- The Trust participated in two national surveys during the course of the year, the National Inpatient Survey and the National Outpatient Survey.

- The National Inpatient Survey sought the views of 850 inpatients of the Trust in the autumn of 2011. 94% of patients rated care as good, very good or excellent and of those 42% rated the care as excellent.

- The National Outpatient Survey sought the views of 850 outpatients of the Trust in the spring of 2011. 97% of patients rated care as good, very good or excellent and of those 53% rated the care as excellent.

- Patients rating the Trust as excellent increased compared to 2009 (last survey) and was above the national average.

- Patients rated the Trust as performing in the top 25% of Trusts nationally in 53% of questions.

## 7. PERFORMANCE AGAINST SELECTED MEASURES

- The Trust has selected a number of measures to indicate what progress has been made during 2010-2011 in three key areas, patient safety, clinical effectiveness and patient experience. These areas have remained the same as in last years Quality Report. The remain unchanged as the Board of Directors consider them to be appropriate measures and wished to ensure continuity of measurement year on year.

- The data presented here is derived from nationally collected data (MRSA; Mortality; Cancelled Operations; Patient Experience; PEAT and Privacy & Dignity) or locally collected data presented to the Board of Directors.

### 7.1 Patient Safety

| **MEASURE** | **2011-2012** | 2010-2011 | 2009-2010 | 2008-2009 |
|---|---|---|---|---|
| Hospital acquired MRSA bacteraemia | **1** | 4 | 0 | 4 |
| Hospital acquired pressure ulcer Grade 3 or Grade 4 | **4** | 7 | 16 | 15 |
| Patient falls from bed or trolley (Note 1) | **28** | 18 | 46 | 63 |

Note 1: Quarter 4 data only

### 7.2 Clinical Effectiveness

| **MEASURE** | **2011-2012** | 2010-2011 | 2009-2010 | 2008-2009 |
|---|---|---|---|---|
| Hospital mortality rate (figure in brackets is expected levels) (Note 2) | **75.6% (100%)** | 108.2% (100%) | 101.6% (100%) | 99.7% (100%) |
| Cancelled operations not readmitted within 28 days | **0%** | 0% | 0% | 0% |

| | | | | |
|---|---|---|---|---|
| Stroke high risk patients treated in 24 hours (45% target) | **80%** | 80% | 85% | 46% |

Note 2: Expected figure derived from Dr Foster data and is standardised for a number of factors. Reporting from 2010-2011 is by relative risk compared to national figures rather than the actual rate.

## 7.3 Patient Experience

| **MEASURE** | **2011-2012** | 2010-2011 | 2009-2010 | 2008-2009 | **National Average (2011-2012)** |
|---|---|---|---|---|---|
| Overall patient satisfaction rated excellent or very good | **83%** | 81% | 81% | 81% | 78% |
| Patient Environment Action Team (PEAT) Inspection Report | **Excellent (environment) Good (food) Excellent (privacy & dignity)** | Excellent (environment) Good (food) Excellent (privacy & dignity) | Excellent (environment) Excellent (food) Excellent (privacy & dignity) | Green | N/A |
| Patient rating of privacy and dignity (inpatient) | **84%** | 84% | 82% | 81% | 80% |

## 8. PERFORMANCE AGAINST NATIONAL TARGETS

The following table details the performance of Poole Hospital NHS Foundation Trust against the national priorities as defined by the Department of Health and declared to the Care Quality Commission. The figures are taken from the March 2012 integrated performance report or, where *, the latest data available.

### TABLE 14 National Target Performances

| | **Target Description** | **2011-2012** | 2010-2011 | 2009-2010 | **Target Figure (2011-2012)** |
|---|---|---|---|---|---|
| 8.1 | Care Quality Commission Standards/Regulated Activities | **16/16** | 16/16 (regulated activities) | 24/24 | 16 |
| 8.2 | Clostridium Difficile Infections | **24** | 42 | 45 | 42 |
| 8.3 | MRSA bacteraemias (bloodstream | **1** | 4 | 0 | 3 |

| | | | | | |
|---|---|---|---|---|---|
| | infections) | | | | |
| 8.4 | Maximum 31 day cancer first treatments | **100%** | 100% | 98% | 96% |
| 8.5 | Maximum 62 day cancer treatments (note 12 month average) | **90%** | 94% | 90% | 85% |
| 8.6 | 18 week maximum wait (admitted patients) | **93%** | 95% | 98% | 90% |
| 8.7 | 18 week maximum wait (non-admitted patients) | **97%** | 98% | 99% | 95% |
| 8.8 | Less than 4 hour wait in A&E | **96%** | 99% | 98% | 95% |
| 8.9 | 31 days to subsequent treatment for all cancers | **99%** | 95% | 98% | 94% |
| 8.10 | 62 days urgent referral to treatment for all cancers | **90%** | 94% | 90% | 85% |
| 8.11 | Thrombolysis within 60 minutes | **100%*** | 75% | 100% | 68% |
| 8.12 | Screening for MRSA | **100%*** | 100% | 100% | 100% |
| 8.13 | Cancer two week wait all cancers | **96%** | 97% | 96% | 93% |
| 8.14 | Cancer two week wait breast cancer | **100%** | 100% | 98% | 93% |

Notes: An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient (during the period under review). Reports of MRSA cases include all MRSA positive blood cultures detected in the laboratories, whether clinically significant or not, whether treated or not
The indicator excludes specimens taken on the day of admission or on the day following the day of admission. Specimens from admitted patients where an admission date has not been recorded, or where it cannot be determined if the patient was admitted, are also attributed to the trust. Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken.

62 Day Cancer Wait. The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer
An urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant (see http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103431.pdf)
The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait) The clock start date is defined as the date that the referral is *received* by the Trust. The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice (A copy of this DSCN can be accessed at: http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/202008.pdf).

In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

### 8.1 Performance Against National Operating Framework

The Department of Health's Operating Framework also includes the following priorities against which Trust performance is noted:

-Delivering same sex accommodation – Trust is Compliant

-Reducing healthcare associated infections - Trust is Compliant

-Delivering cancer targets - Trust is Compliant

-Delivering A&E standards - Trust is Compliant

-Staff satisfaction and engagement - Trust is Compliant

-Reducing emergency readmissions - Trust is Compliant

## 9. OTHER QUALITY IMPROVEMENTS

During 2011-2012 Poole Hospital NHS Foundation Trust made progress on improving the quality of patients care in a number of ways. A selection is reported here:-

### 9.1 Harbourside Gynaecology Centre

The Trust established a new centre for women during 2011. This has enabled patients coming in for gynaecological investigations and treatment to be seen in one purpose designed centre by the appropriate staff. This has been welcomed by patients and their families and means that the whole process around a patient's visit runs much more smoothly.

### 9.2 Mealtime Companions

The Trust has been very conscious of the national reports of the issues around mealtimes for patients and the potential for people to become malnourished. This has prompted the Trust to launch a "mealtime companion" scheme where volunteers are trained to sit with patients and assist them at mealtimes. Volunteers are drawn from all over the Trust and subject to successful training give up their own mealtime to help others.

### 9.3 Newly Refurbished Elderly Care Ward

With the help from generous donations the Trust refurbished a second of its wards for older people. The ward was not simply refurbished but the planning ensured that it is more suitable for people with dementia by coordinating colour schemes to help people orientate more easily and to find their way around. The refurbishment has also provided an increase in single rooms so that issues such as infections, single sex accommodation and disruptive patients can be better managed.

### 9.4 Practice Development Unit Status

The Trust became the first acute Trust in the country to be accredited as a whole Trust Practice Development Unit. This follows the accreditation of a number of units in previous years by Bournemouth University. The accreditation reflects the Trusts commitment to engaging the whole team in developing, learning and delivering the highest quality of care. It singles out the Trust as a place of ongoing practice development.

### 9.5 Trust and Individual Staff Recognition

During 2011-2012 across the Trust a number of members of have been recognised as leaders in their fields through national awards and award nominations. The awards have ranged from national nursing awards, to research awards and innovation awards. This continues a proud tradition of the Trust being recognised nationally for its high quality care and staff.

### 9.6 Keeping Patients and Staff Safe

In May 2010 the Trust was assessed by its insurers, the National Health Service Litigation Authority, against their risk management standards. The Trust achieved a Level 3 assessment mark. This is the highest assessment level and was maintained throughout 2011-2012. The Trust is due for reassessment in spring 2013 and is on course to maintain its assessment level at level 3.

### 9.7 Human Touch Campaign

At Poole Hospital we are justly proud of the service we provide but there is always room for improvement. The Human Touch awareness campaign is a revitalisation of the Poole Approach, to ensure that Trust staff do not lose sight of our primary purpose - safe high quality care of patients.

The care of older, disabled and vulnerable patients has been in the national press repeatedly over the past year and the news has not been good. Report after report (Care Quality Commission, Ombudsman's report, Francis enquiry) has shown that we are not always giving patients and their families the care and support they deserve.

The Human Touch awareness campaign is our response to these concerns - our aim is to promote the ideals of dignity, privacy and respect for all patients. We recognise this is not just an issue for nursing staff. The campaign applies to all members of staff; clinical and non-clinical, including the chief executive and medical director. The Human Touch Campaign was launched in December.

## 10. INVOLVEMENT IN QUALITY

This Quality Report will be presented for approval to the Board of Directors of Poole Hospital NHS Foundation Trust at their May 2012 meeting. At each meeting the Board of Directors receives a comprehensive scorecard containing 45 indicators related to the quality of patients' clinical care.

The Board also considers matters related to care and safety as the first part of its meeting agenda. One part of this consideration is the report of the indepth work on quality, safety and patient experience carried out by the Quality, Safety and Performance Committee, chaired by the vice chairman.

The Quality, Safety and Performance Committee has invited clinical staff from throughout the Trust to present their work and the challenges they face at committee meetings.

The Board of Directors has approved the areas for quality improvement identified in this quality report following detailed discussion at the Quality, Safety and Performance Committee and the Council of Governors.

Supporting the Board of Directors are clinical staff throughout the Trust who are involved in discussions, planning and action around quality improvements.

Directors of the Trust, Care Quality Commission inspectors, commissioners, members of overview and scrutiny committees and patients representatives have visited areas across the Trust accompanying the Director of Nursing, the Medical Director and Matrons on rounds and visits. They have heard first hand from patients, their families and friends about the care and treatment being given.

They have also talked to staff about their views and experiences.
During the year a number of face to face meetings have been held with patients and relatives about their issues with care and treatment. These meetings have helped answer questions and provided the Trust with understanding of how it might improve care and treatment in the future.

Discussions have also taken place with patients and the public concerning quality improvements. Of particular importance has been the work done in conjunction with LINk in a variety of areas. As a result improvements in services to patients have been made in areas such as maternity and patient discharge. Input into approaches to care and to quality have also been sought and given from NHS Commissioners, local authorities and various patient groups.

In February 2012 the Trust together with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust launched a 3 month consultation on the governance arrangements proposed for a new merged organization. Meetings and presentations have been held throughout the area and the public and stakeholder organisations have been actively engaged in the discussions. The consultation closed on 25th April 2012.

## 11. STATEMENTS FROM EXTERNAL BODIES

This Quality Report was sent to:-

- NHS Bournemouth and Poole, NHS Dorset (Lead Commissioner)
- Borough of Poole, Overview and Scrutiny Committee
- Borough of Bournemouth, Overview and Scrutiny Committee
- Dorset County Council, Overview and Scrutiny Committee
- Poole Local Involvement Network (LINk)
- Council of Governors of Poole Hospital NHS Foundation Trust (members of Quality Report Task Group)

The following comments have been made:-

## 11.1 NHS Bournemouth and Poole & NHS Dorset

*"From reviewing the Quality Accounts and from the ongoing monitoring of the Trust throughout 2011/2012, it is evident that the Trust has a strong focus on quality and improving the patient experience. The success of all five quality improvement areas for 2011-2012 is a testament to the work undertaken by all staff at the Trust, which has resulted in a reduction in readmissions, a reduction in delays in discharges, and a reduction in patient's length of stay. Improvements have also been made to the patient experience in children's services and cancer services and the overall mortality rate for the Trust remains well below the national average. Quality improvements have also been seen in other clinical areas, including a reduction in the number of patients falling and a reduction in those patients acquiring pressure ulcers. The national inpatient survey results demonstrated that 9.2 out of ten patients felt that they were treated with dignity and respect which further endorses the positive patient experience.*

*The Trust has also been open and transparent on areas that require further improvement and have throughout the year reacted positively to identified areas of concern. The unannounced visit by the Care Quality Commission highlighted that record keeping was an area where the Trust needed to undertake further work and they promptly developed an action plan, which has been monitored closely by the Cluster PCT at the quality meetings to ensure all actions were completed.*

*The PCT Cluster would like to congratulate the Trust on their continued focus on reducing hospital acquired infections which has resulted in one MRSA bacteraemia and the lowest recorded numbers of Clostridium Difficile in 2011/12.*

*NHS Bournemouth and Poole and NHS Dorset Cluster fully support the quality improvement areas identified for 2012/2013 and looks forward to working with the Trust to enable these improvements".*

## 11.2 Borough of Poole, Overview and Scrutiny Committee

*The Borough of Poole Health and Social Care Overview and Scrutiny Committee is pleased to have the opportunity to comment on the draft quality report for 2011/12.*

*Firstly elected members would like to congratulate the Trust and all staff on both the robustness of the approach and commitment to quality of care demonstrated throughout the report and the standards of care and improvements achieved for local people. The Committee is very pleased to see reported the very high levels of patient satisfaction with quality of care in both in-patient and out-patient services.*

*The Committee would like to make the following specific points:*

1. *Members welcome the progress made to date and the continued commitment to reduce unnecessary hospital readmissions within 30 days of treatment and to reduce the level of delayed hospital discharges. It is recognised that both areas require good partnership work and the Borough of Poole is committed to working with the Trust on these issues.*

2. *The Borough of Poole welcomes and supports the quality improvements identified for 2012/13 and looks forward to receiving information on progress during the year.*

3. *The quality report acknowledges the importance of improving information for patients and their relatives and from the work of the Committee, elected members endorse the importance of this area.*

4. *The report places emphasis on keeping patients and staff safe. The Committee would have liked to have seen direct reference to the contribution that the Hospital makes to adult safeguarding and the Bournemouth and Poole Safeguarding Adults Board.*

5. *The Committee underlines the importance of the Trust's commitment given to the Committee at its meeting in March 2012 to ensure that the high and indeed improving standards of care are given to the public through the process of merger proposed with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. 2012/13.*

6. *The Committee was pleased at its meeting on 22nd May 2012 to hear of improvements made by the Trust as part of its review progress made in relation to implementing the recommendations of the Dignity and Respect Working Party which was a joint Working Party across health and the two Councils. The Committee was particularly pleased to learn of the environmental improvements at the hospital and the initiative to make wards "dementia friendly". The Committee underlines the importance of the Trust implementing the recommendations of the Working Party in full.*

### 11.3 Borough of Poole, Adult Social Care

*The Borough of Poole is pleased to have the opportunity to comment on the draft quality report for 2011/12 and in doing so would like to make the following observations:*

1. *Borough of Poole welcomes the progress made to reduce unnecessary hospital readmissions within 30 days of treatment. This remains a key performance indicator for Borough of Poole, and so we look forward to continued work with Poole Hospital to further reduce readmission rates.*

2. *Borough of Poole notes the significant reduction in the number of people who experience a delayed discharge from hospital. The comment within the report that this performance improvement has been achieved through partnership working with other agencies is very welcome and we take this as recognition of the additional resources invested by Borough of Poole in this area.*

3. *The reduction in length of stay will be a positive indicator from the perspective of patients who neither need nor wish to be in hospital for any longer than necessary. Borough of Poole would, however, wish to note that in some cases (and particularly for older people) a shorter length of stay can result in patients being more dependent at the point of leaving hospital and consequently there has been greater pressure on social care to support people both in residential care homes and within their own home following discharge.*

4. *The Borough of Poole welcomes the quality improvements identified for 2012/13 and in particular supports the aspiration to reduce the number of people being readmitted to hospital, as well as further work to reduce the number of patients who are delayed in hospital prior to discharge.*

5. *The quality report discusses the importance of improving patient information both as part of the plan to support hospital discharge but also as a discrete area for quality improvement at 5.2.1. These measures are*

*welcomed and will support the Borough's own strategic intention to provide increasingly comprehensive information to service users.*

6. *The report at 5.2.3 describes the development of guidance for, amongst other things, hospital discharge and falls prevention. This guidance is important in supporting effective joint work between the local authority and the hospital.*

7. *Borough of Poole would wish to recognise and congratulate the hospital on very high levels of patient satisfaction which are reported in Part 3 of the quality report.*

8. *The report makes reference to keeping patients and staff safe; however, the Borough of Poole is disappointed to see that adult safeguarding does not have a more prominent place in the report.*

9. *In summary, Borough of Poole Adult Social Care has enjoyed a productive working partnership with Poole Hospital NHS Trust throughout 2011/12 contributing to good outcomes for patients, not least demonstrated by the considerable improvement in delayed transfers of care. The reconfiguration of the hospital based social work team has been a significant service development for the Borough and we look forward to working with the Hospital Trust to develop further service improvements in 2012/13.*

### 11.4 Borough of Bournemouth, Overview and Scrutiny Committee

No comments received

### 11.5 Dorset County Council Health Scrutiny Committee

"*We have been sent the draft Quality Account for Poole Hospital Foundation Trust for 2011/12 and I am writing to confirm that there will be no comment from the Dorset Health Scrutiny Committee on the Poole Hospital NHS Foundation Trust Quality Account this year.*

*The Committee decided on the basis of the capacity members have in terms of time that it would only comment on two Quality Accounts this year - The first is Dorset County Hospital NHS Foundation Trust for which is the lead committee and the other is Dorset Healthcare University NHS Foundation Trust because of the breadth and extent of services it provides for residents across the whole of Dorset."*

### 11.6 Poole Local Involvement Network (LINk)


LINk Comment for Poole Hospitals Quality Report 2012

Poole LINk welcomes this opportunity to comment on their work with Poole Hospital over the last year.

## LINk 'Leaving Hospital' Project

The LINk gathered over 1200 comments from local people in 2010/11 and 11% of that feedback was about Poole Hospital. The majority of these Poole Hospital comments related to older people's care, information issues and leaving hospital.

More specific feedback was needed, so we decided to design a survey and ask older people, as they left hospital, what their experience had been. For this project we worked with Poole Hospital Patient Advice & Liaison Service (PALS), Poole Hospital Matrons, Poole Hospital Questionnaire Review Panel, local care homes, domiciliary care agencies and support groups. Hospital staff handed out LINk surveys to everyone who left a Poole Hospital older people's ward during July and August 2011.

Over a quarter of the respondents experienced a delay in their hospital discharge. The main issues raised were about a lack of co-ordination, leading to delayed discharges or home care not arriving. People also told us that they would have appreciated more information.

The LINks Leaving Hospital Report was published in January 2012: http://bit.ly/KI4unR

The report makes 4 recommendations which Poole Hospital has fully accepted and the LINk will be running another 'leaving hospital' survey later this year to follow up on this project. The LINk is also facilitating a networking event this summer for Hospital discharge staff, social services, care homes, domiciliary care agencies, sheltered housing schemes and the local community and voluntary sector.

## Other Joint Work

The LINk has regular contact with the Patient Advice & Liaison Service (PALS) and has been involved in the hospitals disability impact group.

A Poole LINk stewardship group member worked with PALS to carry out an independent 'patient information' audit in November 2011.

The LINk Reading Group (volunteers who give feedback on written information from a patient/carer perspective) has been involved in the redesign of the hospitals discharge survey this year.

Poole Hospital promoted the LINks Youth Survey in November 2011 and a LINk focus group for carers of people with dementia or Alzheimer's in March 2012.

The LINk has recently shared patient and carers feedback about physiotherapy and maternity services with Poole Hospital.

The LINk looks forward to working closely with Poole Hospital this year. The LINks emerging priorities include hospital discharge, young people's issues, drug & alcohol services, the Accident & Emergency department and the proposed hospital merger.

## 11.7 Council of Governors (individual governor comments*)

*The Council of Governors of Poole Hospital NHS Foundation Trust has been in involved in the production of the 2011-2012 Quality Report and particularly the development of the quality improvement priorities for 2012-2013. The Council looks forward to continuing its engagement in the work of the Trust and through their work improving the quality of care and the patient experience of Poole Hospital. The Council commends the Trust for a very good year in delivering quality patient care and a positive patient experience.*

(*This feedback was received verbally).

## ANNEX 1 to QUALITY REPORT 2011-2012

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor 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 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:

1) the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12;

2) 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 2011 to April 2012
-Papers relating to Quality reported to the Board/Board sub-committee over the period April 2011 to April 2012
-Feedback from the commissioners dated 10/05/2012
-Feedback from governors dated 29/05/2012
-Feedback from LINks dated 28/05/2012
-The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27/07/2011, and February 2012;
-The 2011 national patient survey April 2012
-The 2011 national staff survey February 2012
-TheHead of Internal Audit's annual opinion over the trust's control environment dated 04/04/2012
-CQC quality and risk profiles dated; 14/06/2011, 31/07/2011, 30/09/2011, 25/10/2011, 30/11/2011, 31/01/2012, 29/02/2012, 02/04/2012.

3) the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

4) the performance information reported in the Quality Report is reliable and accurate;

5) 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;

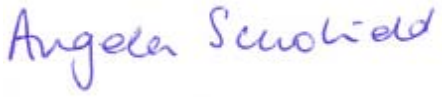
6) the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed 106 definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).
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

NB: sign and date in any colour ink except black

Signed:

Chairman
30 May 2012



Chief Executive
30 May 2012

## ANNEX 2 to QUALITY REPORT 2011-2012

**Independent Auditor's Limited Assurance Report to the Council of Governors of Poole Hospital NHS Foundation Trust on the Annual Quality Report**

We have been engaged by the Council of Governors of Poole Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Poole Hospital NHS Foundation Trust's Quality Report (the 'Quality Report') and specified performance indicators contained therein.

**Scope and subject matter**

The indicators in the Quality Report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA
- Maximum cancer waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as the "specified indicators".

**Respective responsibilities of the Directors and auditors**

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to on page 68, section 5, of the Quality Report (the "Criteria"). The Directors are also responsible for their assertion and the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") issued by the Independent Regulator of NHS Foundation Trusts ("Monitor"). In particular, the Directors are responsible for the declarations they have made in their Statement of Directors' Responsibilities.

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the sources specified below; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the 2011/12 financial year and up to and including April 2012 (the period);
- Papers relating to the Quality Report reported to the Board over the period;
- Feedback from commissioners dated 10/05/2012;
- Feedback from Governors dated 29/05/2012;
- Feedback from LINks dated 28/05/2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27/07/2011 and February 2012;
- National patient survey dated April 2012;
- National staff survey dated February 2012;
- The Head of Internal Audit's annual report over the Trust's control environment dated 04/04/2012; and
- CQC quality and risk profiles dated 14/06/2011, 31/07/2011, 30/09/2011, 25/10/2011, 30/11/2011, 31/01/2012, 29/02/2012 and 02/04/2012.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Poole Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Poole 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 2012, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Poole Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 '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
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the FT ARM to the categories reported in the Quality Report
- Reading the documents.

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

**Limitations**

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

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 thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Directors' interpretation of the Criteria on page 68, section 5, of the Quality Report.

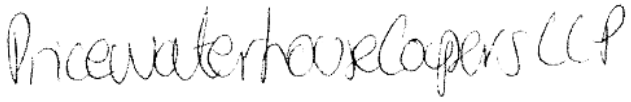
The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Poole Hospital NHS Foundation Trust.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that,

- The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the documents; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria.



PricewaterhouseCoopers LLP
Chartered Accountants
Southampton

30 May 2012

The maintenance and integrity of the Poole Hospital NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

# Annex 1

# Non-financial information

### Regulatory ratings

To ensure NHS foundation trusts remain well-governed, financially viable and legally constituted after authorisation, the trust is regularly assessed and monitored by the independent regulator of foundation trusts, Monitor. Monitor use a combination of financial information and performance against a selected group of national measures as the primary basis for assessing the risk of trusts breaching their authorisation.

Monitor's risk-based framework assigns two risk ratings – financial and governance – to each NHS foundation trust on the basis of its annual plan and in-year performance against that plan. Monitor uses these ratings to guide the intensity of monitoring and to signal to the NHS foundation trust Monitor's degree of concern with specific issues identified and the risk of breach of the authorisation.

In July 2010, as a result of this monitoring, the trust was declared by Monitor to be in significant breach of its authorisation as a result of an operational deficit of £4.5m in 2009/10 and weaknesses in its governance arrangements. In the following 18 months the Trust achieved significant improvements in both its governance processes and in its financial performance:

- Established sound governance processes, including eight new key appointments at both non-executive and executive level
- Achieved sustainable improvements in financial performance moving from an underlying deficit of £6m to an operating surplus of £1m in 2011/12
- Improved its cash balance from £3m in February 2010 to £15m in Mar 2012
- Achieved recurring savings of £16m per annum whilst continuing to deliver high quality, safe patient services and key access and operational targets

As a result of this improvement Monitor confirmed in January 2012 that the Trust was now fully compliant with the terms of its authorisation. The following table demonstrates the corresponding improvement in Monitor's risk rating of the trust.

| | 2010/11 | | | | 2011/12 | | | |
|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **Financial Risk Rating** | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 |
| **Governance Risk Rating** | Red | Red | Red | Red | Red | Red | Amber / Red | Amber / Green |
| **Mandatory Services** | Green | Green | Green | Green | Green | Green | Green | Green |

## Handling complaints

Poole Hospital received 430 formal complaints between 1 April 2011 and 31 March 2012. At the time of preparing this report, 426 had been concluded: 33% were dismissed, 31% were upheld partially, 27% were upheld in their entirety, 5% received reimbursement for loss of property and 4% of complaints were withdrawn.

Eight complaints were referred to the Parliamentary and Health Service Ombudsman.

It is critical that we learn from patients' experiences of our services and examples of learning from complaints included:

- Common medication interactions table made available; additional warning stickers placed on all chemotherapy charts.
- Sharps bin placed in higher position to reduce risk to children in emergency department
- Update of information leaflet on ectopic pregnancies
- Amendment to practice in day theatres so that patients who are unsteady on their feet are transferred on a trolley rather than a wheelchair to reduce the risk of falling.
- Blood testing information in paediatrics now recorded on the electronic patient record as well as in main records.
- Introduction of different prostaglandin to improve induction process.
- Development of information leaflet on care of jejunostomy tubes
- Hospital website corrected with regard to pharmacy opening times
- All radiology requests to have outpatient appointment date indicated on the form and a check to ensure that all imaging for patients is available before the clinic, so that outstanding reports can be completed.
- Retraining in the fitting of air cast boots undertaken as a result of a patient being provided with the incorrect wedges.
- Booking systems in radiotherapy reviewed to ensure that sufficient time is provided.
- Introduction of food and drinks monitor on Ansty ward.
- Introduction of Tannoy system in emergency department to ensure patients hear their names being called.

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## Counter fraud and security

Poole Hospital has adopted the counter fraud and security management services model to deal with fraud and corruption within the National Health Service.

The accountable officer is the director of finance, who is responsible for all operational matters such as authorising investigations, including the arrest, interviewing and prosecution of subjects and the recovery or write-off of any sums lost to fraud.

We have a nominated local counter fraud specialist (LCFS) who is responsible for the investigation of any allegations of fraud and corruption and for the delivery of a programme of pro-active counter fraud work as detailed in the annual work-plan approved by the audit and governance committee. Where fraud is established or improvements to systems or processes identified, the LCFS will recommend appropriate action to the trust.

The LCFS works closely with the human resources department when investigating cases involving members of staff and provides evidence to the trusts investigating officer for disciplinary matters.

Monitoring of the trust's counter fraud arrangements is undertaken by the audit and governance committee. The LCFS attends each committee meeting to report progress against

the agreed counter fraud work-plan and advise the outcome of any completed investigations or pro-active exercises.

We have approved a fraud response plan which sets out these roles and responsibilities and the steps to be taken by the Trust if fraud is suspected. All staff are required to report any suspicions of fraud or corruption that they may have either to the LCFS or the director of finance.

Since 2001 the LCFS has been provided by the Dorset & Somerset Counter Fraud Service (DAS), hosted by NHS Dorset. During this period a number of cases have been successfully investigated at the trust leading to the application of a range of disciplinary, professional and criminal sanctions and financial recovery where appropriate.
An annual independent assessment of the trust's counter fraud arrangements is undertaken as part of the NHS Protect Quality assurance Programme. The most recent assessment relates to the 2010/11 financial year and the Trust was rated at Level 3 – 'organisation performing well'.

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**Research and innovation**

Poole Hospital NHS Foundation Trust is committed to research, development and innovation.

At any one time, up to 250 clinical research projects can be underway, ranging from cardiology to critical care, oncology to rheumatology. The Trust publishes a research and development annual report separately – to request a copy please contact the communications team using the details at the end of this report.

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**Staff engagement**

Poole Hospital is committed to involving staff as fully as possible and in line with the principles set out in the Poole Approach, the philosophy that underpins our values both as an employer and provider of care. The Poole Approach contains pledges that promise we will listen to staff and promote partnership working.

For information on how Poole Hospital NHS foundation Trust works with patients and the public, please see the quality report section.

Staff engagement has been a key element in our response to the 2010 NHS staff survey results in 2011/12. It also informed our handling of the 2011 staff survey and implementing a process of action planning following the release of these results. This commitment to actively listening to our staff and engaging in follow-up actions can be seen in various articles in the weekly staff news bulletin, discussions within clinical divisions and directorates, and the involvement of the Staff Partnership Forum.

Effective engagement remains a priority in our response to the 2011 national NHS staff survey results and is recognised as key to the achievement of targets within the action plan arising from this survey.

The trust provides a range of ways in which staff engagement and involvement is promoted, including:

- The staff partnership forum, which promotes pro-active working with staff representatives on a wide range of issues
- Monthly team briefings, given by the chief executive to senior managers, heads of department and matrons for cascade to all staff through line management arrangements. Team briefings actively encourage dialogue and feedback
- Open briefing sessions for all staff with the chief executive on key issues. All staff are invited to attend these meetings and ask questions; feedback on topics raised at the meeting is provided in the staff news bulletin
- Regular team meetings, held by all directorates, care groups and professional groupings. Regular meetings take place in which staff members are invited to participate and influence, for example the nursing and midwifery executive group and operational managers group
- A new weekly electronic newsletter, the staff bulletin, was launched in 2011/12. It is sent to all email users each week, with instructions to managers to use as part of their face-to-face team briefings. The bulletin welcomes, and considers for publication, all trust-related submitted content from staff.
- Grapevine, the widely-read trust quarterly magazine, focuses on the staff behind the trust's success stories
- The intranet, including a frequently updated 'front page' carrying the latest news
- Staff governor surgeries in the dining room to canvas and record staff views on a range of topics
- Participation in the national NHS staff survey

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**Protecting your information**

Poole Hospital NHS Foundation Trust takes seriously our responsibility to safeguard the confidential information we hold about our patients and staff. Information is provided to staff in a range of ways, including at induction, which highlights individuals' responsibility to protecting the information we hold.

In 2011/12, one serious untoward incident was reported concerning information governance. This related to the unauthorised access of patient records by a staff member in September 2011. Following our investigation, staff working in this area were reminded of their duties with regards to confidentiality and disciplinary action was taken against one staff member.

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**Highlight of the year**

## Trust's stars shine in annual awards

Staff, volunteers and fundraisers who go the extra mile have been recognised at this year's Poole Hospital Awards.

More than 130 guests heard heartfelt, and at times moving, tributes from colleagues, patients and relatives who nominated in this year's recognition scheme.

With a record number of nominations – including for the first time from patients and the public - received this year, the judging panel's job was harder than ever.

Sandbanks Ward, which cares for patients with cancer, was named patient care team award winners. Their nomination, from a patient's relative, described staff on the ward as 'outstanding.'

"I am in awe of the team on Sandbanks ward - there is undoubtedly something special about this group of talented and caring individuals that needs to be recognised," was how one nominator explained the care staff on Sandbanks provide.

Sister Jackie Spendlowe, from Sandbanks Ward, said receiving the award was a real honour.

"We are all extremely proud, and I am so proud of my team," said Jackie.

"It is great to receive recognition for what we have achieved – everyone tries to go that extra mile, and involve not just the patients in their care, but their families too."

The awards, held at The Haven Hotel, Sandbanks, were once again kindly sponsored by local firm Meggitt.

### Recognising long service

In November 2011 the Trust celebrated those staff who had reached milestones of service with the NHS. Congratulations to…

**25 years service**

Jane Armstrong
Pragna Bhatt
Susan Budden
Craig Dean
Jane Edidngton
Janice Fowler
Paula Hurst
Allison Jones
Shelley Kirkham
Annie Lloyd
Maria Lodge
Susan Marshall
Judith Mills
Christine Murphy
Helen Parker
Simon Plain
Samantha Pope
Joanne Rolls
Alison Thomas
Sue Whitney
Janet Williams
Shirley Hunt
Jane LLoyd
Val Horn
David Collier
Julie Barnett
Gary Trent
Mary Sherry
Bob Johnson
Jasmine Hattab
Dorothy Widnall
Sharon Gale
Val Farmer
Carol Fowell
Sue Redfearn

**40 years service**

Richard Finn
Brian Lewry
Glynis Silverman
Gerald Squibb
Alex Wood
Bob Dean

## Equality and diversity

Poole Hospital is committed to equality and diversity, both as a healthcare organisation and as an employer. We have welcomed the provisions of the Equality Act 2010, which replaced existing equality legislation with a single act, and are implementing these across services and for our staff.

Within this positive approach we are working to ensure that our general public duties under the Equality Act are met and form part of our good practice. We also have a commitment to increase engagement on equality issues and to use equality information and analysis to the benefit of patient care and treatment and the support of our staff.

To progress our commitment to continually improving equality performance we have adopted the NHS equality delivery system. In partnership with stakeholders, we have identified four equality objectives and priorities to address over the coming year and relate to better health outcomes for all, improved patient access and experience, empowered, engaged and included staff, and inclusive leadership at all levels.

Equality, diversity, and human rights are also promoted through the Poole Approach, which sets out our values and philosophy of care. The Poole Approach commits us to the provision of 'friendly, professional patient-centred care with respect and dignity for all'. It includes pledges for our staff to treat others with respect and consideration, and value and benefit from diversity in beliefs, cultures, and abilities.

In line with the Poole Approach and the NHS Constitution, Poole Hospital is committed to providing services that do not discriminate on any of the protected characteristics of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. We oppose all forms of unlawful and unfair discrimination.

We are also committed to being a model employer in respect of equality of employment, developing, supporting and sustaining a diverse workforce that is representative of the community it serves (see below).

The Trust is involved in a range of activities aimed at promoting and monitoring equality and diversity. The director of human resources provides leadership of this agenda, supported by the equality and diversity group, which has a broad membership of representatives from within the trust, including the equality lead for human resources and representatives from community and patient groups as well as other NHS organisations in Dorset.

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## A fair employer

Poole Hospital is proud to have been awarded the Jobcentre Plus' 'disability symbol' in recognition of our commitment to equality and fairness for prospective and current employees with disability.

The Trust also operates the guaranteed interview scheme (GIS), established by the Department for Work and Pensions. This means we offer all disabled job applicants who meet the minimum qualifying criteria a guaranteed interview. The aim of this commitment is to encourage people with disabilities to apply for jobs by offering an assurance that should they meet the minimum criteria they will be given the opportunity to demonstrate their abilities at interview.

As the commitment is related to abilities, the minimum criteria will be the essential aspects of the person specification for the position relating directly to an individual's abilities, for example, educational qualifications, skills and abilities. Normal eligibility requirements of a post will need to be fulfilled first before minimum criteria apply, for example to apply for internal positions you must be an existing Trust employee.

A range of support is available both for staff with existing disability and those who develop a disability during their employment. This includes dedicated support from line managers, human resources and occupational health staff. This is underpinned by human resources procedures, including those in the areas of managing attendance, recruitment and also capability. Reasonable adjustments may be made as part of this work, which may include referral to the access to work scheme.

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**Emergency preparedness**

The Trust's Emergency Preparedness Plan provides a comprehensive set of procedures for dealing with sudden major incidents such as fires, explosions and major transport accidents.

Like all hospitals, we regularly test our plans for responding to major incidents to ensure we are properly prepared to care for patients in the event of a major emergency.

Clinical staff and senior managers took part in a number of Trust specific, pan-Dorset and regional exercises to test emergency plans during the year. These included Operation Disapora, regular communication cascades in- and out-of-hours and 'exercise under pressure', which evaluated our response to increased demand on services in winter.

In 2011/12, the following areas and procedures were reviewed:

- CBRN(e) procedure
- Influenza plan
- Emergency preparedness plan (major incident plan)
- Winter plan/capacity management plan
- Human resources business continuity database.

The hospital continues to play an active role in the local resilience forum, working alongside other key category one organisations such as the police, fire, ambulance service and councils to ensure robust plans are in place for dealing with events including chemical, biological, radiological and nuclear (CBRN) incidents, flooding, pandemic flu and other major incidents.

The trust's emergency preparedness group continued to meet regularly through the year to review activities and plan for the future, giving particular consideration to preparations for the forthcoming Olympics in 2012.

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## Reducing risk to patients, staff and visitors

The Trust takes the safety of patients, staff and visitors extremely seriously. Following an inspection by the Health and Safety Executive and subsequent issuing of three improvement notices in April 2011, we have implemented a detailed action plan to ensure our Legionella bacteria management systems are robust.

There have been no cases of patients, staff or the public acquiring Legionella (also known as Legionnaire's) disease during this period, and we are confident the improvement notices will be lifted in June 2012.

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## Estates round-up

During 2011/12 the Trust has invested in major capital developments, including:

### Relocation of CT scanner suite

In January 2012 CT scanning relocated to a new CT suite adjacent to x-ray and the emergency department. This development included purchasing a new CT scanner to offer improved patient care pathways, plus enhanced privacy and dignity for patients. We are grateful for the financial assistance towards the cost of constructing the new suite provided by the Poole Hospital Cancer Treatment Trust and Scanner Appeal, enabling the Trust to increase our overall scanning capacity and to provide better support to major trauma patients.

### Dignity in Dementia ward upgrade

The trust, in partnership with the Kings Fund, has developed a refurbishment scheme to support patients with dementia. The project uses the latest thinking in enhancing the ward environment to support this patient group, and was completed in April 2012.

### Emergency department

Clinical reconfiguration works have been undertaken in our busy emergency department - these works have enhanced the environment for both patients and staff. The works were completed in February 2012.

### Maternity delivery theatre suite

The delivery theatre complex has undergone an extensive refurbishment; the environment now meets the latest engineering standards for operating theatres and provides a safe facility for our expectant mothers. These works were competed in January 2012.

### Infrastructure

The trust has invested £1m in a range of engineering projects to improve the resilience of the hospital. The maintenance and improvement of our estate included water distribution systems, electrical systems, lifts and lighting installations.

A number of other capital projects are currently underway or commencing shortly:

**Magnetic resonance imaging (MRI)**
This summer, the trust will begin scanning patients on its new 3 Tesla (3T) magnetic resonance imaging scanner following a total investment of more than £2.5m. This state-of-the-art development has been made possible by a single major donation in 2008 and generous support from the Poole Hospital Cancer Treatment Trust and Scanner Appeal. MRI activity is forecast to rise steadily in the future due to technology and software advances which make MRI more sensitive to diagnosing pathology allowing earlier diagnosis and treatment of patients. This scanner, which will be the first of its kind in the South West, will provide capacity for an additional 4,000 scans per annum which is an increase in capacity of 40%.

**Upgrade of maternity and neonatal intensive care (NICU) services**
The Trust has, for a long time, had an ambition to relocate maternity services to a new building more suited to the requirements of modern services. This remains the long term strategy of the Trust but will not be achievable within the next four to five years.
The existing St Mary's Maternity Unit dates back to 1930. This building was extended in 1961 with the addition of the central delivery suite (CDS) and neonatal intensive care unit (NICU), including the special care baby unit (SCBU), and finally extended in 1984 with the addition of a post natal ward and antenatal clinic.
In order to ensure the sustainable delivery of high quality and safe services over the next three to five years, the Trust invested £700,000 in 2011/12 in the upgrade of its two maternity theatres in CDS. This work was completed in December 2011 and the board has now committed a further £2m to a major refurbishment of the building.

This investment will address important environmental issues that the service currently faces and will provide sufficient capacity to address anticipated growth over the next few years.

**Four-year information management and technology investment programme**
In 2011/12 Poole and The royal Bournemouth and Christchurch Hospitals NHS Foundation Trust commissioned an external review to assess current IT services and propose a future IM&T strategy for the two trusts. Recommendations which have been agreed in principle include the creation of single informatics service and an outline four year investment programme in:

- IT infrastructure to improve robustness and reliability
- core clinical systems
- electronic patient record including electronic document management

**Private Patient Unit**
The board has agreed to invest £500,000 in additional and dedicated capacity to treat private inpatients separately within the trust. This will be achieved through the establishment of a new ward for private patients on B5, to be called The Cornelia Private Patient Centre. The new centre will open in August/September 2012 and will enable the trust to meet increasing demand from consultants, and patients, who wish to benefit from private patient facilities managed by the trust.

**Radiotherapy**
The trust's Dorset Cancer Centre is the major specialist cancer treatment facility for adults in the county providing a wide range of treatments including radiotherapy and chemotherapy for both common and rare cancers. Radiotherapy contributes to around 40% of cases where a cancer is cured. This figure could rise further with the implementation of new technologies such as intensity modulated radiotherapy (IMRT), intensity modulated arc therapy (IMAT) and image guided radiotherapy (IGRT) offering image guided four-dimensional adaptive radiotherapy.

Our goal is to routinely deliver these technically advanced treatments at the earliest opportunity to ensure that patients in Dorset receive the best treatment possible and therefore the best opportunity for a cure.

As part of its growth strategy for the Dorset Cancer Centre, the trust is investing more than £6m million over the next 18 months into essential infrastructure and treatment enhancements. The investments include upgrades for the two Varian linear accelerators (known as 'Linacs') in order to offer the latest image guided radiotherapy, replacement of the oldest of the four existing units and a new radiotherapy bunker to enable new units to be commissioned and existing units to be maintained without down-time.

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**Public consultation**

In early 2012, a joint public consultation was carried out with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust on a proposed merger of the two organisations.

The consultation, which ran from 1 February to 25 April 2012, was on the proposed governance arrangements for the new merged organisation. These will ensure there is a robust and solid foundation on which to build for the future, as the two Trusts form a single and strong organisation. It was not a consultation on service reconfiguration; this will be for the new Foundation Trust to take forward.

**What did the Trusts consult on?**
Views were sought on a range of proposed constitutional governance arrangements for the new organisation. These included:

- Membership boundaries and constituencies
- Size and composition of the council of governors
- Minimum ages for membership, voting and standing as governor
- Size and composition of the board of directors
- Constitution
- Elections.

The Trusts also asked for views on the name of the new organisation.

**Consultation activities**
Throughout the consultation period the trusts carried out a number of communication activities with our councils of governors, including:

- Regular staff briefing sessions
- Attendance at Health Overview and Scrutiny Committees
- Staff publications, including regular monthly briefings and articles in weekly Staff Bulletin and Grapevine newsletter
- Proactive media relations
- Nearly 200 local stakeholder contacts, including health partners, community groups, hard to reach groups
- Dedicated joint website
- Intranet page
- Local publications, including local authorities and some resident magazines

- Public meetings held across the catchment area of Dorset, Wiltshire and Hampshire, including attending local resident meetings on request
- Governor distribution of posters and leaflets within their constituencies
- Drop-in sessions in the 'harder to reach' areas of Swanage, Blandford, Gillingham and New Milton
- Information to members via the members' newsletter
- LCD/TV screens in patient areas of the hospital
- Leaflets and posters within outpatient and public areas of the hospital
- Wide circulation of the consultation document internally and externally.

Following the consultation, responses will be collated and a summary circulated to both local stakeholders and to any individual that gave feedback during the consultation. The summary will also be published on the trust's website and in part 1 of the board of directors meetings.

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**Summary of performance - NHS staff survey 2011**

Details of the key findings from the 2011 NHS staff survey are outlined below. These include comparisons between the Trust's results for the previous year, and the national average. The top and bottom four ranking scores are included along with key areas where we have seen real improvement.

The four lowest scoring areas form part of the trust's programme of action to achieve and sustain improvements in these areas.

| | 2010/11 | | 2011/12 | | Trust improvement/ deterioration |
|---|---|---|---|---|---|
| | Trust | National Average | Trust | National Average | |
| Response rate (compared to national average for acute trusts) | 58% | 51% | 60% | 52.5% | Increase by 2 % points |

| Top 4 Ranking Scores in 2011 survey (Key Finding in brackets) | Trust | National Average | Trust | National Average | |
|---|---|---|---|---|---|
| Staff believing the trust provides equal opportunities for career progression or promotion (KF 37) | 90% | 90% | 92% | 90% | Increase by 2 % points |
| Impact of health and well-being in ability to perform work or daily activities (KF 28) | 1.55 score | 1.57 score | 1.52 Score | 1.56 score | Decrease in score by .03 point |
| Percentage of staff reporting errors, near misses or incidents | 96% | 95% | 97% | 96% | Increase by 1 % point |

| | | | | | |
|---|---|---|---|---|---|
| witnessed in the last month (KF 21) | | | | | |
| Percentage of staff saying hand washing materials are always available (KF 19) | 67% | 67% | 69% | 66% | Increase by 2 % points |

| Bottom 4 Ranking Scores in 2011 survey (Key Finding in brackets) | Trust | National Average | Trust | National Average | |
|---|---|---|---|---|---|
| Trust commitment to work-life balance (KF 7) | 3.19 score | 3.38 score | 3.12 score | 3.36 score | Decrease in score by .07 point |
| Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (KF 1) | 68% | 74% | 65% | 74% | Decrease by 3 % points |
| Percentage of staff receiving job-relevant training, learning or development in last 12 months (KF 11) | 75% | 78% | 71% | 78% | Decrease in 4 % points |
| Support from immediate managers (KF 15) | 3.52 score | 3.61 score | 3.45 Score | 3.61 score | Decrease in score by .07 point |

**Key areas of improvement**

The 2011 results found that staff undergoing equality and diversity training, had seen a significant increase, from 24% to 45% (KF 36).

In addition, the percentage of staff receiving health and safety training had also increased, from 76% in 2010 to 83% in 2011 (KF16).

**Future priorities and targets**

Key overall priority areas and targets for improvement have been agreed in response to the 2011 survey results in the form of a trust-wide ‘high level’ action plan. This includes the key findings which have highlighted area for further improvement, including commitment to work/life balance, support from immediate managers and training relevant to roles.

This work is set at Board of Director level through the Workforce Committee.

In addition to the trust-wide action plan, a pro-active response to directorate and divisional staff survey results is made, involving divisional and corporate directors and their teams. This is in the form of setting specific targets and related actions and priorities at directorate and divisional level.

**Future priorities and how they will be measured**

The approach of agreeing 'high level' priority areas accompanied by a directorate and divisional approach supports target setting and the identification of actions which take account differences in staff views across different parts of the organisation. This shows staff that their views are listened to. Measurement of all actions will be through the directorate of human resources.

**Monitoring arrangements**

Monitoring actions against targets is co-ordinated within the directorate of human resources. Reports on survey results, action planning and activity against targets are made to the board of directors through the Workforce Committee.

**Other disclosures in the public interest - health**

The trust has an active multidisciplinary Wellbeing at Work Group, led by the directorate of human resources. This group actively responds to identified staff wellbeing issues across the organisation, including workplace stress. A key element of the group's work is to ensure full implementation of the related NICE public health guidance.

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**Environmental and sustainability report**

The Trust continues to make strides to improve our carbon footprint in line with the NHS' carbon reduction strategy.

The Trust continues to invest in the latest technology to meet its own energy target of an 18% reduction by 2015. The Trust is working alongside industry professionals to replace our combined heat and power generators for a more efficient plant which is balanced to the Trust's energy outputs/needs.

In order to achieve these targets, Poole Hospital continues to support its Carbon Management Implementation Plan (CMIP). The plan sets out our commitment towards reducing carbon emissions, identifies where we will focus our efforts, and states how and when we intend to achieve our goals. The Trust continues to develop low-cost measures such as good housekeeping and an education and awareness programme to support the plan. Smart technology is being used to support our longer term plans such as building management system upgrades, intelligent lighting and the use of alternative technologies.
Poole Hospital is registered with the Good Corporate Citizenship scheme and is due to undertake a further assessment on sustainability. The Sustainability Management Plan brings together:

- Our carbon reduction commitment
- The principles contained within the Good Corporate Citizen Model
- Our 'travel to work' commitments

- Minimum design criteria for our new developments
- A new Energy Policy to help reduce consumption
- A clear plan to undertake and achieve certification by the Carbon Trust Standard

A combination of better recycling and waste management at Poole Hospital ensures we operate full site recycling in conjunction with Poole Borough Council to help actively reduce the amount of waste going to landfill sites. Our main theatres have an enhanced waste stream achieving a higher recycling rate. Cardboard waste continues to be recycled through the use of a mini compactor and collection is made by the local authority. We are also developing new waste streams including recycling food waste from our main kitchens.

Our purchasing procedures are continually being refined to help minimise waste and enable packaging to be returned to suppliers where practicable - carbon footprint is part of the selection criteria too.

The annual clinical waste audit identified no significant areas of concern regarding compliance. A waste bin audit was commissioned to assist with segregation and fire compliance; the findings are currently being reviewed.

Working with the Carbon Management Trust has helped us focus on the implementation of our Carbon Management Plan will help us achieve a carbon emission reduction in line with the national NHS target of 15% by 2015, also a Carbon Reduction Opportunities Assessment was completed on behalf of the Carbon Trust which investigated potential opportunities to save carbon through energy efficiencies.

The Trust has worked hard in identifying and minimising waste wherever possible and has just completed an extensive review of our Building Management System heating controls to better manage heating levels.

**Future priorities and targets**

The Carbon Management Plan sets out responsibilities regarding performance target and monitoring reporting procedures. The establishment of Sustainability Working Groups will ensure that all clinical and non clinical measures are taken to reduce carbon emissions to

help achieve our 18% target which is greater than the required 15%.

A developed Sustainability Strategy will pull together all the threads of sustainability into one cohesive strategy encompassing:

- Good Corporate Citizen – working towards becoming a Foundation Trust advocate in developing and achieving the South West Regional target
- Travel to Work – review and evaluation of our current travel to work patterns, methodologies and alternatives, including the use of subsidised public transport
- Carbon Reduction – our established target to reduce carbon is set at 18% by 2015. The Trust continues to fund our Carbon Management Plan (CMP) which will deliver the required emission reduction and subsequent savings
- Energy Management – an update to our current Energy Policy reflecting the projects identified within the CMP and establishing minimum room temperatures and controlling the use of split air conditioning units
- The continual review of the impact that the Carbon Reduction Commitment (CRC) will have on the Trust's activities both financially and operationally in terms of priorities.

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# Financial report

## Charitable income (unaudited)

Total charitable income received during the period amounted to £991k and £998k was spent.

The balance of funds held at 31 March 2012 totalled £4,270k. This sum includes £172k in tangible fixed assets, which relates to the Health Information and Resource Centre.

Charitable income figures are unaudited.

## Management costs

The Trust seeks to maximise expenditure on direct patient care whilst maintaining a sensible balance with its expenditure on management and administration.

| | Year to 31 March 2012 £000 |
|---|---|
| Management costs | **7,451** |
| Income | **195,052** |
| Management costs as a percentage of income | **3.8%** |

Management costs are as defined as those on the management costs website at http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en

## Better Payment Practice Code

| | Year to 31 March 2012 Number | £000 |
|---|---|---|
| Total bills paid within target | **38,877** | **69,153** |
| Total bills paid in the year | **42,242** | **76,335** |
| **Percentage of bills paid within target** | **92%** | **91%** |

The Better Payment Practice Code requires the Trust to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

**The Late Payment of Commercial Debts (Interest) Act 1998**

No interest was paid during the year to 31 March 2012.

**HM Treasury and Office of Public Sector Information**

The Trust complies with the cost allocation and charging requirements set out in the HM Treasury and Office of Public Sector Information guidance.

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# Annual accounts 2011/12

**Accounts: see Annex 2**

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# Auditor's opinion

**Independent Auditors' Report to the Council of Governors of Poole Hospital NHS Foundation Trust**

We have audited the financial statements of Poole Hospital NHS Foundation Trust for the year ended 31 March 2012 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2011/12 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

**Respective responsibilities of directors and auditors**
As explained more fully in the Directors' Responsibilities Statement set out on page 5 the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12. Our responsibility is to audit and express an opinion on the financial statements in accordance with the NHS Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Poole Hospital NHS Foundation Trust in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

The maintenance and integrity of the Poole Hospital NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

**Scope of the 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 the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

**Opinion on financial statements**

In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12, of the state of the NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure and cash flows for the year then ended; and

- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

**Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts**

In our opinion

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12; and

- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we are required to report by exception**

The Audit Code for NHS Foundation Trusts requires us to report where we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We draw your attention to the NHS Foundation Trust's Annual Governance Statement on page 117. Monitor considers that from July 2010 to January 2012, the NHS Foundation Trust was in contravention of and had failed to comply, with the terms of its Authorisation, which require it to exercise its functions "effectively, efficiently and economically" and the contravention and failure were significant.

Consequently, we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, for the greater part of the financial year, and our certificate is qualified in this respect.

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or

- we have qualified our report on any aspects of the Quality Report.

**Qualified Certificate**

Monitor considers that from July 2010 to January 2012, the NHS Foundation Trust was in contravention of and had failed to comply with the terms of its Authorisation which require it to exercise its functions "effectively, efficiently and economically", and the contravention and failure were significant. We have, therefore, been unable to satisfy ourselves that the NHS Foundation Trust has put in place adequate arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Anna Blackman (Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Savannah House
3 Ocean Way, Southampton, SO14 3TJ

30 May 2012

# Annual governance statement for Poole Hospital NHS Foundation Trust

## 1. Scope of responsibility

1.1 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.

## 2. The purpose of the system of internal control

2.1 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:-

2.1.1 identify and prioritise the risks to the achievement of the policies, aims and objectives of Poole Hospital NHS Foundation Trust; and

2.1.2 evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

2.2 The system of internal control has been in place in Poole Hospital NHS Foundation Trust for the whole of year ended 31 March 2012 and is up to the date of approval of the Annual Report and Accounts.

## 3. Capacity to handle risk

3.1 The risk management process is led by a nominated Director for Risk, supported by Divisional Directors, Clinical Directors, Matrons, Department Leads and an Assistant Director who heads a small team of risk managers

3.2 Staff have been trained or equipped to manage risk in a way appropriate to their authority and duties. This has been done by risk management sessions on induction, risk assessment and root cause analysis training sessions, bi-yearly health and safety training and access to the Risk Management Team for advice. There has been a monthly Risk Management and Safety Committee meeting whereby lessons learnt and good practice is submitted for disseminating down through the organisation.

## 4. The risk and control framework

4.1 The Trust has a Risk Management Strategy in place, the key elements of which include the identification of risk, evaluating the impact of risk on patients, staff and visitors, and identifying control measures that can be put in place to

minimise the risk. The Strategy describes the key responsibilities of all staff including risk reporting. It sets out the risk management process and information requirements and includes links to audits and external reviews of the process.

4.2 The key ways in which risk management has been embedded in the activity of the Trust are:-

4.2.1 Trust wide Adverse Incident Reporting procedure for all staff. The NPSA national reporting and learning service shows the Trust continues to be a top performer in reporting incidents;

4.2.2 risks (corporate, clinical and information governance) and action plans to mitigate risk are discussed at the quarterly performance review meetings led by the Chief Executive involving Clinical Divisions and Directorates;

4.2.3 monthly Risk Management and Safety Group meetings with representation from all Clinical Divisions and Directorates where a wide range of risk issues are discussed and Trust-wide trends and analysis are reviewed;

4.2.4 regular specialist risk management groups meet and discuss incidents that have occurred and recommendations made. Clinical Divisions/Directorate trends and analysis are reviewed;

4.2.5 risk being discussed at monthly Clinical Divisions/Directorate clinical governance and business meetings;

4.2.6 risk assessments being performed throughout the Trust and risks added to the Risk Register. A Risk Review Group validates risks and red risks are reported to the Risk Management and Safety Group on a monthly basis. The Board of Directors' Audit and Governance Committee receive a report on new red and amber risks at each meeting. The Quality, Safety and Performance Committee discuss relevant clinical risks.

4.2.7 bi-monthly Health and Safety Committee meetings are held;

4.2.8 recommendations from Serious Untoward Incidents are monitored by the Board of Directors and the Quality and Safety Committee;

4.2.9 key personnel sit on both the Risk Management and Safety Group and the Quality, Safety and Performance Committee

4.2.10 quarterly internal performance reviews of Clinical Divisions and Directorates where there is a requirement to report on risks, risk assessment and action to mitigate risk.

4.2.11 the Board of Directors reviewed the key strategic risks during the year and received a monthly report on the changes to these risks during the year.

4.2.12 the Trust has an active Council of Governors which includes representatives of all the key public stakeholders. The Council and individual governors are involved in taking action to manage risks which impact on both the Council and stakeholder organisations.

4.3 The Trust has an Assurance Framework which includes:-

4.3.1 principal corporate objectives, whereby the Trust's key objectives have been taken from the following key documents: NHS Operating Framework, Annual Accountability Agreement with NHS Dorset and NHS Bournemouth and Poole, Service Level Agreements with other organisations and The Trust's Annual Plan;

4.3.2 principal risks were identified against each corporate objective, focusing on both risks that would prevent the Trust from attaining the objective and the principal risks identified in implementing the objective. A simple risk assessment was then conducted against each risk, assisting the Board to recognise threats and prioritise risk treatment plans;

4.3.3 key controls & systems are identified and systems and processes are listed that currently help control the risks identified;

4.3.4 the Assurance Framework has been linked to the relevant entries to the Trust Risk Register and

4.3.5 the controls assurance process provides a list of evidence showing that the key controls and systems exist and that they are as effective as possible. Assurance is provided to the Board of Directors on this via the meetings of Sub Committees of the Board of Directors who receive minutes of the Hospital Executive Group and other key executive groups for scrutiny.

4.4 The Trust has identified gaps in the Assurance Framework around:-

4.4.1 Strategic future:- The Trust has moved towards a merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to secure high quality healthcare for local populations.

4.4.2 Meeting all national targets:- The Trust has dealt with gaps in endoscopy waiting and with the help of partner agencies reduced delayed discharges.

4.4.3 Legionella risk:- The Trust has been working to close the gap in the risks associated with the management of legionella following the imposition of three improvement notices from the HSE in April 2011.

4.5 The Trust's Quality, Safety and Performance Committee has provided assurance on quality governance issues including compliance with the Care Quality Commission's registration requirements, the production of the annual quality report and quality standards.

4.6 The Trust is registered unconditionally to carry out all its activities with the Care Quality Commission and is compliant with all but one of the essential standards of quality and safety. The Trust is working through a detailed action plan to deliver compliance.

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

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

4.9 As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Annual benefits statements are not issued to individuals.

## 5. Review of economy, efficiency and effectiveness in the use of resources

5.1 The Trust employs a number of internal mechanisms and external agencies to ensure the best use of resources

5.1.1 Executive Directors and Managers have responsibility for the effective management and deployment of their staff and other resources to maximise the efficiency of their Directorates and Clinical Divisions.

5.1.2 Board of Directors - A Non-Executive Director chairs the Audit and Governance Committee at which representatives of the internal and external auditors attend. The Committee reviewed and agreed the audit plans of both the internal and external auditors. The plans specifically include economy, efficiency and effectiveness reviews which have been reported on. A Non-Executive Director also chairs the Finance and Investment Committee which reviews the Trust's finance plans and performance. The Board of Directors receives both performance and financial reports at each of its meetings and receives reports of its Sub Committees to which it has delegated powers and responsibilities.

5.2 In July 2010 the Trust was judged by Monitor to be in significant breach of its Authorisation as a result of a reported operational deficit of £4.5m in 2009/10 and weaknesses in its governance arrangements. Since July 2010 the Trust has achieved significant improvements in both its governance processes and in its financial performance including the establishment and delivery of a challenging financial recovery. The Trust returned to full compliance with the Trust's Authorisation in January 2012.

## 6. Annual Quality Report

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

6.2 The production of the quality report is led by the Director of Nursing and reflects the discussions and decisions of the Board of Directors and the Quality, Safety and Performance Committee during the proceeding year.

6.3 The Trust has engaged clinical staff, the board, governors, LINks, health scrutiny panels in the process of building the quality report.

6.4 The data used in the quality report has been reviewed and a number of data items are the subject of external audit scrutiny to check their validity.

6.5 Clinical quality and patient safety have been at the forefront of meetings of the Board of Directors and the Trust has continued to hold a regular Quality, Safety and Performance Committee to provide further assurance on the arrangements for maintaining clinical quality and patient safety.

## 7. Review of effectiveness

7.1 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 audits 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, and comments made by the external auditors in their management letter and other reports.

7.2 The system of internal control is subject to scrutiny at the Audit and Governance Committee and reported to the Board of Directors. The Audit and Governance Committee are informed by the outcomes of a programme of work by internal audit and the scrutiny of external auditors.

7.3 I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me.

7.4 Monitor, the independent regulator of foundation Trusts, found the Trust in breach of its terms of authorisation with respect to its general duty to exercise its functions effectively, efficiently, and economically in July 2010. The Trust returned to full compliance with the Trust's Authorisation in January 2012. However as a result of the Trust remaining in breach for the first 9 months of the year the auditors have not been able to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and their certificate in this report is qualified in this regard.

7.5 The Trust has been working on a financial recovery plan to address the issues of the breach and excellent progress has been made during the course of the year. The Trust achieved compliance with the terms of authorisation in January 2012. Notwithstanding the breach of authorisation during this year I have received assurance on the robustness of other governance arrangements from a variety of sources. My review is also informed by the external auditors in their management letter and other reports.

7.6 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit and Governance Committee, Quality, Safety and Performance Committee, Workforce Committee,

Information Group and Risk Management and Safety Group. Plans to address weaknesses and ensure continuous improvement of the system are in place.

7.7 On an operational level, the Trust has been reviewed on its compliance with the outcomes of the Care Quality Commission and the Clinical Negligence Scheme for Trusts (CNST)/NHS Litigation Authority Risk Management Standards. During the year the Trust has maintained a Level 3 assessment under the NHSLA Risk Management Standards for acute trusts and Level 1 for Maternity Standards under CNST.

## 8. Conclusion

**8.1 Based upon available Department of Health guidance, and the Trust's internal and external auditors' views, the Board of Directors, other than the financial position of the Trust (see section 5.2 and 7.4 above), has not identified any significant internal control issues at this time.**

Chris Bown
Chief executive

30 May 2012

# Annex 2
# Annual accounts 2011/12

## FOREWORD TO THE ACCOUNTS

### Poole Hospital NHS Foundation Trust

These accounts for the year ended 31 March 2012 of Poole Hospital NHS Foundation Trust have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and comply with the annual reporting guidance for NHS foundation trusts within the NHS Foundation Trust Annual Reporting Manual (FT ARM) for the financial period.

**Signed:** 

**Chief Executive and Accounting Officer**

**Name: Christopher Bown**

**Date: 28 May 2012**

**Statement of the Chief Executive's responsibilities as the Accounting Officer of Poole Hospital NHS Foundation Trust**

The National Health Service 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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed the Poole Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Poole 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 NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts (Monitor).

**Christopher Bown, Chief Executive**

**Date: 28 May 2012**

## STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2012

| | NOTE | 2011/12 £000 | Re-stated 2010/11 £000 |
|---|---|---|---|
| **Operating income** | 2 | **195,686** | 194,795 |
| **Operating expenses** | 3 | **(192,737)** | (190,729) |
| **OPERATING SURPLUS** | | **2,949** | **4,066** |
| **Finance Costs** | | | |
| Finance income | 5 | **145** | 59 |
| Finance costs - financial liabilities | 6 | **(36)** | (54) |
| Finance costs - interest expense - unwinding of discount | 16 | **(14)** | (7) |
| Public Dividend Capital dividends payable | | **(2,928)** | (3,044) |
| **Net Finance Costs** | | **(2,833)** | (3,046) |
| **SURPLUS FOR THE YEAR (See Note a below)** | | **116** | **1,020** |
| **Other comprehensive (expense)/income** | | | |
| Impairments/Revaluations | | **1,093** | 2,624 |
| Other recognised gains and losses | | **0** | (2) |
| **TOTAL COMPREHENSIVE (EXPENSE)/INCOME FOR THE YEAR** | | **1,209** | **3,642** |

Note a : The Surplus for the year amounting to £116k includes impairment of £1,473k and reversal of impairment of £634k in respect of property, plant and equipment following the revaluation of the estate by the District Valuer as at 31 March 2012.

Note b: Previous year's figures have been re-stated - see Note 1.19

The notes on the following pages form part of these accounts.

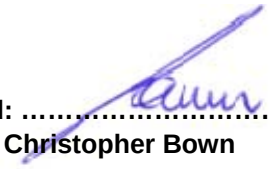
All income and expenditure is derived from continuing operations.

## STATEMENT OF FINANCIAL POSITION AS AT 31 March 2012

| | NOTE | 31 March 2012 £000 | Re-stated 31 March 2011 £000 | Re-stated 1 April 2010 £000 |
|---|---|---|---|---|
| **NON CURRENT ASSETS** | | | | |
| Intangible assets | 7 | **596** | 519 | 160 |
| Property, plant and equipment | 8 | **101,520** | 102,409 | 98,946 |
| Trade and other receivables | 11 | **979** | 1,071 | 1,100 |
| | | **103,095** | 103,999 | 100,206 |
| **CURRENT ASSETS** | | | | |
| Inventories | 10 | **1,931** | 2,052 | 2,237 |
| Trade and other receivables | 11 | **6,938** | 5,527 | 8,751 |
| Cash and cash equivalents | 17 | **15,358** | 8,969 | 4,535 |
| **TOTAL CURRENT ASSETS** | | **24,227** | 16,548 | 15,523 |
| **CURRENT LIABILITIES** | | | | |
| Trade and other payables | 12.1 | **(21,105)** | (17,454) | (16,188) |
| Borrowings | 13 | **(316)** | (316) | (316) |
| Provisions | 16 | **(999)** | (86) | (110) |
| Other liabilities | 12.2 | **0** | (271) | (237) |
| **TOTAL CURRENT LIABILITIES** | | **(22,420)** | (18,127) | (16,851) |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | | **104,902** | 102,420 | 98,878 |
| **NON CURRENT LIABILITIES** | | | | |
| Borrowings | 13 | **(223)** | (516) | (830) |
| Provisions | 16 | **(524)** | (520) | (340) |
| Other liabilities | 12.2 | **0** | 0 | (16) |

| | | | |
|---|---|---|---|
| **TOTAL NON CURRENT LIABILITIES** | **(747)** | (1,036) | (1,186) |
| **TOTAL ASSETS EMPLOYED** | **104,155** | 101,384 | 97,692 |
| **FINANCED BY:** | | | |
| **TAXPAYERS' EQUITY** | | | |
| Public dividend capital | **87,611** | 86,049 | 85,999 |
| Revaluation reserve | **9,330** | 10,005 | 7,383 |
| Income and expenditure reserve | **7,214** | 5,330 | 4,310 |
| **TOTAL TAXPAYERS' EQUITY** | **104,155** | 101,384 | 97,692 |

Note: prior year figures have been restated - for further details see Note 1.19.
The financial statements on pages 126 to 172 were approved by the Board on 28 May 2012 and signed on its behalf by:



**Signed: ……Chief Executive** **Date: 28 May 2012**
**Name: Christopher Bown**

**Signed: ……Director of Finance** **Date: 28 May 2012**
**Name: Paul D. Turner**

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

| | Public dividend capital (PDC) | Revaluation reserve | Donated asset reserve | Income and Expenditure Reserve | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Balance at 31 March 2011** | **86,049** | **10,005** | **0** | **5,330** | **101,384** |
| **Changes in taxpayers' equity for 2011/12** | | | | | |
| Total Comprehensive Income for the year: | | | | | |
| Retained surplus/(deficit) for the year | 0 | 0 | 0 | 116 | 116 |
| Impairments/Revaluations charged to the Revaluation Reserve (refer to Notes 8.1 and 8.2) | 0 | 1,093 | 0 | 0 | 1,093 |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve | 0 | (1,768) | 0 | 1,768 | 0 |
| Public Dividend Capital received | 1,562 | 0 | 0 | 0 | 1,562 |
| **Balance at 31 March 2012** | **87,611** | **9,330** | **0** | **7,214** | **104,155** |
| **Balance at 1 April 2010** | **85,999** | **3,032** | **6,757** | **1,904** | **97,692** |
| Prior period adjustment (see Note 1.19) | 0 | 4,351 | (6,757) | 2,406 | 0 |
| **Restated Balance at 1 April 2010** | **85,999** | **7,383** | **0** | **4,310** | **97,692** |
| **Changes in taxpayers' equity for 2010/11** | | | | | |
| Total Comprehensive Income for the year: | | | | | |
| Retained surplus for the year | 0 | 0 | 0 | 1,020 | 1,020 |
| Impairments/Revaluations charged to the Revaluation Reserve (refer to Notes 8.3 and 8.4) | 0 | 2,624 | 0 | 0 | 2,624 |
| Other transfers between reserves | 0 | 0 | 0 | 0 | 0 |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve | 0 | 0 | 0 | 0 | 0 |
| Other recognised gains and losses | 0 | (2) | 0 | 0 | (2) |
| Public Dividend Capital received | 50 | 0 | 0 | 0 | 50 |
| **Balance at 31 March 2011** | **86,049** | **10,005** | **0** | **5,330** | **101,384** |

Note. Prior year figures have been restated - for further details see Note 1.19.

## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2012

| | 2011/12 £000 | Re-stated 2010/11 £000 |
|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | |
| **Operating surplus from continuing operations** | **2,949** | **4,066** |
| | | |
| **Non-cash income and expense:** | | |
| Depreciation and amortisation | 8,859 | 8,274 |
| (Reversal of impairments)/Impairments | 839 | (5,228) |
| (Increase)/decrease in trade and other receivables | (1,319) | 3,253 |
| (Increase)/decrease in other assets | 0 | 0 |
| (Increase)/decrease in inventories | 121 | 185 |
| Increase/(decrease) in trade and other payables | 2,324 | 1,266 |
| Increase/(decrease) in other liabilities | (271) | 18 |
| Increase/(decrease) in provisions | 917 | 156 |
| Other movements in operating cash flows | 189 | 102 |
| **Net cash generated from operations** | **14,608** | 12,092 |
| | | |
| **Cash flows from investing activities** | | |
| | | |
| Interest received | 145 | 59 |
| Purchase of property, plant and equipment | (6,486) | (3,901) |
| Purchase of intangible assets | (197) | (397) |
| Sales of property, plant and equipment | 0 | 0 |
| **Net cash generated used in investing activities** | **(6,538)** | (4,239) |
| | | |
| **Cash Flows from financing activities** | | |
| | | |
| Public dividend capital received | 1,562 | 50 |
| Capital element of finance lease rental payments | (293) | (314) |
| Interest element of finance lease | (36) | (54) |
| PDC Dividend paid | (2,914) | (3,101) |
| Cash flows from other financing activities | 0 | 0 |
| **Net cash used in financing activities** | **(1,681)** | (3,419) |
| | | |
| **Increase in cash and cash equivalents** | **6,389** | 4,434 |
| | | |
| **Cash and Cash equivalents at 1 April** | **8,969** | 4,535 |
| | | |
| **Cash and Cash equivalents at 31 March** | **15,358** | 8,969 |

# NOTES TO THE ACCOUNTS

## 1 ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's FreM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts with the exception of any changes to accounting policies.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.

The Trust has prepared the financial statements on a going concern basis. In light of the possible merger with The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust, the Trust has considered whether the principle of going concern is appropriate for its circumstances. The Foundation Trust Annual Reporting Manual states that the financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so. Should the merger with The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust proceed, this will be on the basis that the services currently provided by the Trust will be transferred to the new FT which would be formed following the merger. As work on the possible merger progresses, the Trust has also developed financial plans for the next three years, as part of the annual planning process, which demonstrate the Trust is financially sustainable. As such the Trust believes it is appropriate to prepare these accounts on a going concern basis.

### 1.1 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, that income is deferred. When a patient is admitted and treatment begins, then the income for that treatment or spell can start to be recognised. Income relating to these spells which are partially completed at the financial year end is therefore accrued for. In respect of March activity actual activity is not known before the accounts are closed. A judgement is therefore made on the level of income to accrue for this activity.

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.

### 1.2 Expenditure on Employee Benefits

#### Short-term Employee Benefits

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

#### Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation the FReM requires that "the period between formal valuations shall be four years with approximate assessments in intervening years". An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 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), published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the Foundation Trust.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

### 1.3 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

### 1.4 Property, Plant and Equipment

**Recognition**

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

Property, Plant and Equipment assets are capitalised if they are capable of being used for a period which exceeds one year and they:
- individually have a cost of at least £5,000; or

- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- 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. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

**Measurement**

**Valuation**

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

All land and buildings are re-valued using professional valuations in accordance with IAS16 every five years although valuations have been carried out more regularly. A three year interim valuation is also carried out. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. At 31 March 2009 (with an effective date of 1 April 2008) the land and buildings were re-valued on a modern equivalent asset basis (MEA). Further valuations were undertaken with effective dates of 31 March 2010, 31 March 2011 and 31 January 2012 with no material changes noted in the period 31 January 2012 to 31 March 2012. See also Note 1.18 regarding critical estimates and key accounting judgements.

**Subsequent expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

**Depreciation**

Items of Buildings and Dwellings are depreciated over their remaining useful economic lives on a straight line basis, in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an indefinite life and is not depreciated. Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Equipment is depreciated on a straight line basis, over the estimated life of the asset, as detailed in the following
categories:

| **Type of Asset** | **Economic Life** |
|---|---|
| Plant & Machinery | 5-15 years |
| Transport Equipment | 7 years |
| Information Technology | 5-10 years |
| Furniture & Fittings | 10 years |

**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 income.

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 FT ARM, impairments that are due to a loss 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) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising 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 is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

**De-recognition**

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:
• management are committed to a plan to sell the asset;
• an active programme has begun to find a buyer and complete the sale;
• the asset is being actively marketed at a reasonable price;
• the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
• the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following 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.

**Donated, government grant and other grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Further details of the change in acounting policy can be found on note 1.19.

## 1.5 Intangible assets

### Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not
capitalised as intangible assets.
Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;

• the Trust has the ability to sell or use the asset;

• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and

• the Trust can measure reliably the expenses attributable to the asset during development.

### Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

### Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

### Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

## 1.6 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

## 1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. The material management stock system values the stock at latest invoice price. Pharmacy stock is valued at average price. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks.

## 1.8 Financial instruments and financial liabilities

### Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial Items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

### De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

### Classification and Measurement

Financial assets are categorised as loans and receivables. Financial liabilities are classified as 'Other Financial liabilities'.

### Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: current investments, 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.

### Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

### Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

## 1.9 Leases

### Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate

implicit in the lease. The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment. The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

**Operating leases**

Other leases are regarded as operating leases and the rentals are charged to operating expenses or over the term of the lease. Operating lease incentives received are added to the lease rentals and ch expenses over the life of the lease.

**Leases of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building compone classification for each is assessed separately.

## 1.10 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% (2010/11: 2.9%) in real terms.

**Clinical negligence costs**
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 16 but is not recognised in the NHS Foundation Trust's accounts.

**Non-clinical risk pooling**
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Foundation Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

## 1.11 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 20, 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.

### 1.12 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) net cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

### 1.13 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### 1.14 Corporation Tax

The NHS Foundation Trust has carried out a review of corporation tax liability on its non-healthcare activities. At present all activities are either ancillary to the Trust's patient care activity or are below the de minimus level at which corporation tax is due.

### 1.15 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

### 1.16 NHS Charitable Funds

Monitor has obtained an additional dispensation for 2011/12 and 2012/13 from HM Treasury to the application of IAS 27 by NHS foundation trusts in relation to the consolidation of NHS charitable funds. The disclosure requirements of the standard will, however, apply for 2013/14 as the Trust considers the NHS Charitable Fund to be a subsidiary of the NHS Foundation Trust under IAS 27.

### 1.17 Description of Reserves

Revaluation Reserve relates to revaluation gains on the estate following valuations by the District Valuer.
Income and Expenditure Reserve relates to accumulated surpluses by the Foundation Trust.

### 1.18 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS Foundation Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

Losses and Special Payments are disclosed in Note 26 and relate mainly to the NHSLA policy excesses on third party and employer's liability claims against the Trust.

### 1.19 Prior Period Adjustment

In common with NHS organisations nationally, the Foundation Trust has been required to restate the donated asset reserve as a prior period adjustment. This is the result of changes in accounting requirements for donated assets within Monitor's Foundation Trust Annual Reporting Manual (FT ARM).

This has resulted in a number of adjustments to the prior year financial statements. The impact of these has been summarised below:

| | £'000 |
|---|---|
| **Surplus for the year as reported within the 2010/11 financial statements** | **1,140** |
| Increase in income from receipts of donated and Government granted assets | 84 |
| Increase in expenditure as a result of depreciation on, and disposal of, government granted and donated assets | **(204)** |
| **Surplus for the 2010/11 year as reported within the 2011/12 financial statements** | **1,020** |

All relevant notes have comparative figures shown at 1 April 2010.

The treatment is in line our revised accounting policy per note 1.4 to the financial statements.

Donated assets
Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated. The donated reserve at 1 April 2010 amounting to £6,757k has been allocated to the revaluation reserve (£4,351k) and income and expenditure reserve (£2,406k).

Government grants
Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated. Property, Plant and Equipment has been reduced by £18k and deferred income has been reduced by £18k.

## 1.20 Accounting Standards issued but not adopted

The following recent standards have been issued but not yet adopted by the NHS:

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on the accounts for 2011-12, were they applied in that year:
• IAS 1 Presentation of financial statements (Other Comprehensive Income) - this standard is applicable for periods beginning on or after 1 July 2012, the standard has not yet been EU endorsed
• IAS 12 - Income Taxes (amendment) - this standard is applicable for periods beginning on or after 1 January 2012 but the standard has not yet been EU endorsed
• IAS 19 Post-employment benefits (pensions) - this standard is applicable for periods beginning on or after 1 January 2013, the standard has not yet been EU endorsed
• IAS 27 Separate Financial Statements - this standard is applicable for periods beginning on or after 1 January 2013, the standard has not yet been EU endorsed
• IAS 28 Investments in Associates and Joint Ventures - this standard is applicable for periods beginning on or after 1 January 2013, the standard has not yet been EU endorsed
• IAS 32 Financial instruments: Presentation on Offsetting financial assets and financial liabilities – this standard is applicable for periods beginning on or after 1 January 2014
• IFRS 9 Financial Instruments – this standard is applicable for periods beginning on or after 1 January 2013, the standard has not yet been EU endorsed
• IFRS 10 Consolidated Financial Statements - this standard is applicable for periods beginning on or after 1 January 2013, the standard has not yet been EU endorsed
• IFRS 11 Joint Arrangements - this standard is applicable for periods beginning on or after 1 January 2013, the standard has not yet been EU endorsed
• IFRS 12 Disclosure of Interests in Other Entities - this standard is applicable for periods beginning on or after 1 January 2013, the standard has not yet been EU endorsed
• IFRS 13 Fair Value Measurement - this standard is applicable for periods beginning on or after 1 January 2013, the standard has not yet been EU endorsed

## 1.21 Critical estimates and key accounting judgements

Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The following areas of the financial statements are subject to key estimates and judgements.

### Valuation of the Trust's estate

A valuation of the Trust's land and buildings was undertaken with an effective date of 31 January 2012 by the District Valuer. The valuations have been undertaken applying the principles of IAS 16 'Property, Plant and Equipment' and RICS advises that assumptions underpinning the concepts of fair value should be explicitly stated and identifies two potential qualifying assumptions:

* "the Market Value on the assumption that the property is sold as part of the continuing enterprise in occupation" (effectively Existing Use Value); or
* "the Market Value on the assumption that the property is sold following a cessation of the existing operations" (in effect the traditional understanding of Market Value).

The Department of Health has indicated that for NHS assets it requires the former assumption to be applied for operational assets; this is the approach that was taken by the DV. The Market Value used in arriving at fair value for operational assets is therefore subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

The Trust estimates the pattern of consumption of property, plant and equipment by writing assets down on a straight line basis over useful economic lives. The useful economic lives determined for each asset or group of assets are informed by historical experience or specific information provided by the District Valuer where appropriate.

**Recoverability of accounts receivable**

Amounts receivable from NHS organisations are generally considered to be recoverable based on historical experience, however specific provisions are made against non-NHS receivables when it is considered prudent to do so having considered the age of the receivable and other factors. The value of this provision is disclosed in note 11.

**Other estimates and judgements**

Estimates and judgements are also made in respect of provisions for liabilities and charges (see Note 16) and contingent liabilities (see Note 20) where there is some uncertainty at the Statement of Financial Position date as to either the timing or amount of the Trust's financial liability.

The Trust also makes a significant estimate for amounts due from its commissioners in respect of partially completed spells at the Statement of Financial Position date, which is supported by patient activity data and historical experience.
The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of 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 2.2% in real terms terms except for early retirement provisions and injury benefit provisions which both use the HM Treasury’s pension discount rate of 2.8% in real terms.

In the view of the Trust there are no further estimates or judgements which if wrong could materially affect financial performance.

## 2 Operating Income

### 2.1 Operating Income

| Income from Activities | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| Elective income | **26,303** | 24,706 |
| Non elective income | **71,793** | 74,338 |
| Outpatient income | **24,814** | 21,910 |
| A & E income | **5,227** | 5,386 |
| Other NHS Clinical Income | **47,770** | 44,298 |
| Other types of activity income | **1,520** | 1,449 |
| Private patient income | **1,514** | 1,442 |
| | **178,941** | 173,529 |

| Other Operating Income | 2011/12 £000 | Re-stated 2010/11 £000 |
|---|---|---|
| Education and training | **5,859** | 5,981 |
| Charitable and other contributions to expenditure (Note 1) | **301** | 699 |
| Non-patient care services to other bodies | **4,784** | 5,327 |
| Reversal of impairment property, plant and equipment | **634** | 5,891 |
| NHS income for staff costs accounted on a gross basis Note 2) | **1,422** | - |
| Income generation (Note 3) | **1,709** | 1,806 |
| Other income | **2,036** | 1,562 |
| | **16,745** | 21,266 |
| **Total Operating Income** | **195,686** | **194,795** |

Note 1. Monitor has confirmed the delay in implementing IAS27 and does not require Foundation Trusts to consolidate accounts of charities or include charitable funds in Financial Risk Ratings. It is anticipated that consolidation will take place in 2013/14.

Note 2. As part of the Whole of Government Accounting exercise the Foundation Trust was required to change its accounting treatment of salary recharge costs to other foundation trusts for 2011/12 only and show these recharges as income in order to eliminate differences of accounting treatment between Government bodies on consolidation.

Note 3. Income generation relates mainly to restaurant income and car park income received by the Trust

## 2.2 Private Patient Income

| | 2011/12 | 2010/11 | Base Year 2002/03 |
|---|---|---|---|
| | **£000** | £000 | £000 |
| Private patient income | **1,514** | 1,442 | 1,473 |
| Total patient related income | **178,941** | 173,529 | 95,931 |
| **Proportion** | | | |
| Cap | | | 1.5% |
| **Actual** | **0.8%** | 0.8% | |

The proportion of private patient income to the total patient related income of Poole Hospital NHS Foundation Trust does not exceed its proportion whilst the body was an NHS Trust in 2002/03 the base year. Private patient income has been re-defined by Monitor during the year. Private patient income now includes income which is attributable either directly or indirectly and which has its origin in the provision of goods and services to non-NHS patients.

## 2.3 Mandatory and Non-Mandatory Income from Activities

| | 2011/12 | 2010/11 |
|---|---|---|
| | **£000** | £000 |
| Mandatory | **175,907** | 170,638 |
| Non-Mandatory | **3,034** | 2,891 |
| **Actual** | **178,941** | 173,529 |

## 2.4 Income from Activities by Source

| | 2011/12 | 2010/11 |
|---|---|---|
| | **£000** | £000 |
| Primary Care Trusts | **175,035** | 170,418 |
| Local Authorities (see Note 1) | **127** | 151 |
| Department of Health | **0** | - |
| NHS Other | **990** | - |
| Non NHS: Private patients | **1,514** | 1,442 |
| Non-NHS: Overseas patients (non-reciprocal) | **22** | 103 |
| NHS injury scheme (see Note 2) | **1,014** | 1,113 |
| Non NHS: Other | **239** | 302 |
| | **178,941** | 173,529 |

Note 1. Local authority income relates mainly to the reimbursement of costs associated with delayed patient discharges.

Note 2. NHS injury scheme income is subject to a provision for doubtful debts of 10.5% (2010/11 9.6%) to reflect expected rates of collection.

## 3 Operating Expenses and Operating Lease Costs

### 3.1 Operating Expenses (by type):

| | 2011/12 | Re-stated 2010/11 |
|---|---|---|
| | **£000** | £000 |
| Services from other Foundation Trusts | **1,838** | 1,117 |
| Services from NHS trusts | **234** | 632 |
| Services from other NHS bodies | **218** | 489 |
| Purchase of healthcare from non NHS bodies | **32** | 25 |
| Employee Expenses - Executive Directors' costs (Note 4) | **959** | 1,081 |
| Employee Expenses - Non Executive Directors' costs (Note 4) | **131** | 121 |
| Employee Expenses - Staff (Note 4) | **125,778** | 126,379 |
| Redundancy | **1,072** | 369 |
| Supplies and services - clinical drugs | **17,669** | 16,510 |
| Supplies and services - clinical other | **13,346** | 13,795 |
| Supplies and services - general | **4,670** | 4,786 |
| Establishment | **2,133** | 1,955 |
| Transport | **821** | 846 |
| Premises | **5,048** | 4,581 |
| Bad debts | **130** | 189 |
| Depreciation and amortisation | **8,859** | 8,274 |
| Impairment of property, plant and equipment | **1,473** | 663 |
| Audit fees - statutory audit (see Note b) | **88** | 102 |
| Audit fees - prior year audit fees (see Note b) | **19** | 14 |
| Consultancy Costs | **977** | 2,951 |
| Clinical negligence Insurance Costs | **4,954** | 4,139 |
| Other Services including External Payroll | **550** | 605 |
| Training and course fees etc. | **424** | 366 |
| Legal Fees | **251** | 76 |
| Loss on Disposal of Other Property, plant and Equipment | **218** | 54 |
| Other (Note c) | **845** | 610 |
| | **192,737** | 190,729 |

Note a. 2010/11 figures have been restated and expenditure has increased by £204k due to the revised accounting treatment of donated and Government granted assets. See note 1.19 for further details.

Note b. The Council of Governors has appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the Trust. The audit fee for the statutory audit on the annual accounts and quality report was £73k excluding VAT (2010/11 £78k). Prior year audit fees of £19k has been included in the current year as they were not accrued in 2010/11. The engagement letter signed on 9 November 2011, states that the liability of PwC, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1m in the aggregate in respect of all services.

Note c. Other includes annual subscriptions (£142k); compensation payments (£119k); insurance (£111k): licence fees (£33k).

**3.2 Arrangements containing an operating lease**

| | **2011/12** | 2010/11 |
|---|---|---|
| | **£000** | £000 |
| **Minimum lease payments** | **139** | 132 |
| | **139** | 132 |

| | **2011/12** | 2010/11 |
|---|---|---|
| | **£000** | £000 |
| **Future minimum lease payments due (see Note):** | | |
| Not later than one year | **139** | 133 |
| Later than one year and not later than five years | **556** | 532 |
| Later than five years | **554** | 600 |
| | **1,249** | 1,265 |

Note: The operating lease payments due after five years relate to TOPS Day Nursery and the Staff Residences (see Note 22).

## 3.3 Segmental Reporting

IFRS 8 defines the term of Chief Operating Decision Maker (CODM) as a group or individual whose 'function is to allocate resources to and assess the performance of the operating elements of the entity'. For the Trust, the most appropriate interpretation is that the Board of Directors represents the CODM. Operational performance is monitored at the monthly board meetings and key resource allocation decisions are agreed there.

Information is presented to the Board as a single operating segment and is under full IFRS. This mirrors the information that is submitted to Monitor and enables the Board to make strategic decisions on the Annual Plan.

This information for the year ending 31st March 2012 is shown in the table to this note.

The Trust generates the majority of its income from healthcare and related services. The information as displayed in the accounts reflects that which is submitted to the Board.

The Trust had two major customers during the year 2011/12 as follows: Bournemouth & Poole, and Dorset PCTs, representing 61% and 23% of its total income respectively.

**Summary of Key Financial Information 2011/12**

| | Year to 31 March 2012 | | |
|---|---|---|---|
| | **Actual** | **Original Plan** | **Variance** |
| | **£'000** | **£'000** | **£'000** |
| **Income** | 195,052 | 188,116 | 6,936 |
| **Operating Expenditure** | 182,187 | 176,844 | 5,343 |
| **EBITDA** | 12,647 | 11,272 | 1,375 |
| **EBITDA %** | 6.50% | 6.00% | 0.50% |
| **Surplus before impairment** | **955** | **157** | 798 |
| **Impairment** | (839) | - | (839) |
| **Surplus after impairment** | 116 | 157 | (41) |
| **Cost Improvement Savings** | 9,749 | 11,181 | (1,432) |
| **Cash Balance** | 15,358 | 8,971 | 6,387 |
| **Capital Expenditure** | 7,710 | 6,983 | 727 |
| **FRR (Financial Risk Rating)** | 3 | 3 | - |

The change in the accounting treatment of donated income/assets has increased the planned surplus from the £157k shown above to £2.5m as a result of plans to spend £3m on donated assets during 2011/12. However two major items have been delayed until 2012/13 resulting in a shortfall on donated income in 2011/12 of £2.7m.

2010/11 figures are not available as a similar report was not presented to the Board in that year.

## 4 Employee costs and numbers

### 4.1 Employee Expenses

| | 2011/12 Total | 2010/11 Total |
|---|---|---|
| | **£000** | £000 |
| Salaries and wages | **104,875** | 105,621 |
| Social Security Costs | **8,162** | 8,040 |
| Employer contributions to NHS Pension Scheme | **12,641** | 12,500 |
| Termination Payments | **1,072** | 369 |
| Agency/Contract Staff | **1,059** | 1,299 |
| | **127,809** | 127,829 |

### 4.2 Average Number of Employees

| | 2011/12 Total | 2010/11 Total |
|---|---|---|
| | **Number** | Number |
| Medical and dental | **368** | 372 |
| Administration and estates | **585** | 613 |
| Healthcare assistants and other support staff | **160** | 173 |
| Nursing, midwifery and health visiting staff | **1,196** | 1,262 |
| Scientific, therapeutic and technical staff | **266** | 273 |
| Bank and Agency Staff (see Note) | **155** | 166 |
| Other | **318** | 318 |
| Total | **3,048** | 3,177 |

Note: Bank and agency staff numbers are estimated based on the average equivalent cost of similar NHS staff positions.

### 4.3 Employee Benefits

No additional benefits were paid to staff in the financial periods.

### 4.4 Retirements due to ill-health

During 2011/12 there were five (2010/11 eight) early retirements on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £526k (2010/11 £443k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division. This information has been supplied by NHS Pensions.

## 4.5 Staff Exit Packages

| Exit package cost band | 2011/12 Number of Compulsory Redundancies | 2011/12 Cost of Compulsory Redundancies | 2011/12 Number of Other Departures Agreed | 2011/12 Cost of Other Departures Agreed | 2011/12 Total Number of Exit Packages | 2011/12 Total Cost of Exit Packages | 2010/11 Total Number | 2010/11 Total cost |
|---|---|---|---|---|---|---|---|---|
| | | £000 | | £000 | | £000 | | £000 |
| Less than £10,000 | 1 | 4 | 6 | 32 | **7** | **36** | 2 | 11 |
| Between £10,000 and £25,000 | 0 | 0 | 2 | 39 | **2** | **39** | 0 | 0 |
| Between £25,001 and £50,000 | 1 | 43 | 3 | 87 | **4** | **130** | 1 | 25 |
| Between £50,001 and £100,000 | 1 | 92 | 1 | 50 | **2** | **142** | 2 | 182 |
| **Total** | **3** | **139** | **12** | **208** | **15** | **347** | **5** | **218** |

## 4.6 Remuneration of Directors

| | 2011/12 Total | 2011/12 Benefits in Kind | 2011/12 Employer's Pension Contributions | 2011/12 Employer's National Insurance | 2011/12 Remun-eration |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Executive Directors | **959** | 0 | 103 | 88 | 768 |
| Non Executive Directors | **131** | 0 | 0 | 10 | 121 |
| **Total** | **1,090** | **0** | **103** | **98** | **889** |

| | 2010/11 Total | 2010/11 Benefits in Kind | 2010/11 Employer's Pension Contributions | 2010/11 Employer's National Insurance | 2010/11 Remuner-ation |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Executive Directors | **1,081** | 0 | 83 | 68 | 930 |
| Non Executive Directors | **121** | 0 | 0 | 10 | 111 |
| **Total** | **1,202** | **0** | **83** | **78** | **1,041** |

Note: The detail of the Directors' remuneration has been disclosed in the 2011/12 remuneration report within the Annual Report of the Foundation Trust.

## 5 Finance Income

| | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| Interest on Loans and Receivables | **145** | 59 |
| | **145** | 59 |

## 6 Finance Costs - Interest Expense

| | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| Finance Leases | **36** | **54** |
| | **36** | 54 |

## 7 Intangible Assets

| | Software licences £000 | Total £000 |
|---|---|---|
| Gross cost at 1 April 2011 | 613 | 613 |
| Additions - Purchased | 197 | 197 |
| Additions - Donated | 0 | 0 |
| **Gross cost at 31 March 2012** | **810** | **810** |
| Amortisation at 1 April 2011 | 94 | 94 |
| Charged during the year | 120 | 120 |
| **Amortisation at 31 March 2012** | **214** | **214** |
| **Net book value** | | |
| - Purchased at 1 April 2011 | 455 | 455 |
| - Donated at 1 April 2011 | 64 | 64 |
| **- Total at 1 April 2011** | **519** | **519** |
| - Purchased at 31 March 2012 | 544 | 544 |
| - Donated at 31 March 2012 | 52 | 52 |
| **- Total at 31 March 2012** | **596** | **596** |

## 8.1 Property, Plant and Equipment 2011/12

**Tangible fixed assets at the Statement of Financial Position date comprise the following elements:**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant and machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1 April 2011 | 11,903 | 71,240 | 1,442 | 325 | 34,651 | 28 | 8,565 | 467 | 128,621 |
| Additions purchased | 0 | 1,621 | 0 | 2,443 | 1,942 | 0 | 1,507 | 0 | 7,513 |
| Additions donated | 0 | 28 | 0 | 0 | 247 | 0 | 26 | 0 | 301 |
| Impairments/Revaluations charged to the Revaluation Reserve | (24) | (2,676) | (17) | 0 | 0 | 0 | 0 | 0 | (2,717) |
| Impairments charged to the Statement of Comprehensive Income | (4) | (1,469) | 0 | 0 | 0 | 0 | 0 | 0 | (1,473) |
| Reversal of Impairments charged to the Statement of Comprehensive Income | 0 | 634 | 0 | 0 | 0 | 0 | 0 | 0 | 634 |
| Reclassifications | 0 | 678 | 0 | (999) | 321 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | (2,295) | 0 | (1,021) | 0 | (3,316) |
| **Cost or Valuation at 31 March 2012** | **11,875** | **70,056** | **1,425** | **1,769** | **34,866** | **28** | **9,077** | **467** | **129,563** |
| **Depreciation at 1 April 2011** | **0** | **0** | **0** | **0** | **20,246** | **25** | **5,583** | **358** | **26,212** |
| Charged during the year | 0 | 3,701 | 129 | 0 | 3,645 | 1 | 1,239 | 24 | 8,739 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation surpluses | 0 | (3,681) | (129) | 0 | 0 | 0 | 0 | 0 | (3,810) |
| Disposals | 0 | 0 | 0 | 0 | (2,140) | 0 | (958) | 0 | (3,098) |
| **Depreciation at 31 March 2012** | **0** | **20** | **0** | **0** | **21,751** | **26** | **5,864** | **382** | **28,043** |
| **Net book value** | | | | | | | | | |
| - Purchased at 31 March 2011 | 11,903 | 65,809 | 1,442 | 325 | 12,179 | 3 | 2,976 | 109 | 94,746 |
| - Donated at 31 March 2011 | 0 | 5,431 | 0 | 0 | 1,426 | 0 | 6 | 0 | 6,863 |
| - Finance Lease at 31 March 2011 | 0 | 0 | 0 | 0 | 800 | 0 | 0 | 0 | 800 |
| **- Total at 31 March 2011** | **11,903** | **71,240** | **1,442** | **325** | **14,405** | **3** | **2,982** | **109** | **102,409** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| - Purchased at 31 March 2012 | 11,875 | 64,718 | 1,425 | 1,769 | 11,408 | 2 | 3,183 | 85 | 94,465 |
| - Donated at 31 March 2012 | 0 | 5,318 | 0 | 0 | 1,196 | 0 | 30 | 0 | 6,544 |
| - Finance Lease at 31 March 2012 | 0 | 0 | 0 | 0 | 511 | 0 | 0 | 0 | 511 |
| **- Total at 31 March 2012** | **11,875** | **70,036** | **1,425** | **1,769** | **13,115** | **2** | **3,213** | **85** | **101,520** |

## 8.2 Analysis of Property, Plant and Equipment at 31 March 2012

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Net book value** | | | | | | | | | |
| - NBV - Protected assets at 31 March 2012 | 11,165 | 66,785 | 0 | 0 | 0 | 0 | 0 | 0 | 77,950 |
| - NBV - Unprotected assets at 31 March 2012 | 710 | 3,251 | 1,425 | 1,769 | 13,115 | 2 | 3,213 | 85 | 23,570 |
| **- Total at 31 March 2012** | **11,875** | **70,036** | **1,425** | **1,769** | **13,115** | **2** | **3,213** | **85** | **101,520** |

Of the totals at 31 March 2012, £710k related to land valued at open market value and £1,425k related to buildings valued at open market value.

## 8.3 Property, Plant and Equipment 2010/11 (Restated)

**Tangible fixed assets at the Statement of Financial Position date comprise the following elements:**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant and machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Cost or valuation at 1 April 2010** | **12,440** | **64,792** | **1,442** | **0** | **35,316** | **28** | **7,888** | **467** | **122,373** |
| Additions purchased | 0 | 949 | 0 | 325 | 1,169 | 0 | 823 | 0 | 3,266 |
| Additions donated | 0 | 498 | 0 | 0 | 137 | 0 | 0 | 0 | 635 |
| Impairments/Revaluations charged to the Revaluation Reserve | (537) | (227) | 0 | 0 | 0 | 0 | 0 | 0 | (764) |
| Impairments charged to the Statement of Comprehensive Income | 0 | (663) | 0 | 0 | 0 | 0 | 0 | 0 | (663) |
| Reversal of Impairments charged to the Statement of Comprehensive Income | 0 | 5,891 | 0 | 0 | 0 | 0 | 0 | 0 | 5,891 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | (1,971) | 0 | (146) | 0 | (2,117) |
| **Cost or Valuation at 31 March 2011** | **11,903** | **71,240** | **1,442** | **325** | **34,651** | **28** | **8,565** | **467** | **128,621** |
| Depreciation at 1 April 2010 | 0 | 0 | 0 | 0 | 18,494 | 23 | 4,576 | 334 | 23,427 |
| Charged during the year | 0 | 3,269 | 119 | 0 | 3,669 | 2 | 1,153 | 24 | 8,236 |
| Reclassification | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation Surpluses | 0 | (3,269) | (119) | 0 | 0 | 0 | 0 | 0 | (3,388) |
| Disposals | 0 | 0 | 0 | 0 | (1,917) | 0 | (146) | 0 | (2,063) |
| **Depreciation at 31 March 2011** | **0** | **0** | **0** | **0** | **20,246** | **25** | **5,583** | **358** | **26,212** |
| **Net book value** | | | | | | | | | |
| - Purchased at 1 April 2010 | 12,440 | 59,778 | 1,442 | 0 | 13,976 | 5 | 3,304 | 133 | 91,078 |
| - Donated at 1 April 2010 | 0 | 5,014 | 0 | 0 | 1,735 | 0 | 8 | 0 | 6,757 |
| - Finance Lease at 1 April 2010 | 0 | 0 | 0 | 0 | 1,111 | 0 | 0 | 0 | 1,111 |
| **- Total at 1 April 2010** | **12,440** | **64,792** | **1,442** | **0** | **16,822** | **5** | **3,312** | **133** | **98,946** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| - Purchased at 31 March 2011 | 11,903 | 65,809 | 1,442 | 325 | 12,179 | 3 | 2,976 | 109 | 94,746 |
| - Donated at 31 March 2011 | 0 | 5,431 | 0 | 0 | 1,426 | 0 | 6 | 0 | 6,863 |
| - Finance Lease at 31 March 2011 | 0 | 0 | 0 | 0 | 800 | 0 | 0 | 0 | 800 |
| **- Total at 31 March 2011** | **11,903** | **71,240** | **1,442** | **325** | **14,405** | **3** | **2,982** | **109** | **102,409** |

**8.4 Analysis of Property, Plant and Equipment at 31 March 2011:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Net book value** | | | | | | | | | |
| - NBV - Protected assets at 31 March 2011 | 11,185 | 67,914 | 0 | 0 | 0 | 0 | 0 | 0 | 79,099 |
| - NBV - Unprotected assets at 31 March 2011 | 718 | 3,326 | 1,442 | 325 | 14,405 | 3 | 2,982 | 109 | 23,310 |
| **- Total at 31 March 2011** | **11,903** | **71,240** | **1,442** | **325** | **14,405** | **3** | **2,982** | **109** | **102,409** |

Of the totals at 31 March 2011, £718k related to land valued at open market value and £1,442k related to buildings valued at open market value.

Note: The net book value of Property, Plant and Equipment has been restated for 2010/11 and reduced by £18k due to the revised accounting treatment of Government granted assets. See Note 1.19 for further details.

**8.5 The net book value of Property, Plant and Equipment at 31 March 2012 comprises:**

| | 31 March 2012 | Restated 31 March 2011 |
|---|---|---|
| | £000 | £000 |
| **Freehold** | | |
| Protected | 77,950 | 79,099 |
| Unprotected | 23,570 | 23,310 |
| **TOTAL** | **101,520** | **102,409** |

Note: The net book value of Property, Plant and Equipment has been restated for 2010/11 and reduced by £18k due to the revised accounting treatment of Government granted assets. See Note 1.19 for further details

**8.6 Net book value of assets held under finance leases**

**Tangible fixed assets at the Statement of Financial Position date comprise the following elements:**

| | Plant and machinery | Total |
|---|---|---|
| | £000 | £000 |
| Cost or valuation at 1 April 2011 | 1,960 | 1,960 |
| Additions purchased | 0 | 0 |
| Additions donated | 0 | 0 |
| Impairments charged to revaluation reserve | 0 | 0 |
| Reclassifications | 0 | 0 |
| Revaluation surpluses | 0 | 0 |
| Disposals | 0 | 0 |
| **Cost or Valuation at 31 March 2012** | **1,960** | **1,960** |
| Depreciation at 1 April 2011 | 1,160 | 1,160 |
| Charged during the year | 289 | 289 |
| Reclassifications | 0 | 0 |
| Revaluation surpluses | 0 | 0 |
| Disposals | 0 | 0 |
| **Depreciation at 31 March 2012** | **1,449** | **1,449** |
| **Net book value** | | |
| - Purchased at 1 April 2011 | 800 | 800 |
| - Donated at 1 April 2011 | 0 | 0 |
| **- Total at 1 April 2011** | **800** | **800** |
| - Purchased at 31 March 2012 | 511 | 511 |
| - Donated at 31 March 2012 | 0 | 0 |
| **- Total at 31 March 2012** | **511** | **511** |

Finance leases relate to medical equipment assets.

## 10.1 Inventories

| | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Materials | 1,931 | 2,052 |
| **TOTAL** | **1,931** | 2,052 |

## 11.1 Trade receivables and other receivables

| | Total 31 March 2012 | Financial assets at 31 March 2012 | Non-financial assets at 31 March 2012 | Total 31 March 2011 | Financial assets at 31 March 2011 | Non-financial assets at 31 March 2011 |
|---|---|---|---|---|---|---|
| **Current** | | | | | | |
| | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| NHS Receivables | 3,771 | 3,771 | 0 | 2,061 | 2,061 | 0 |
| Other receivables with related parties | 191 | 191 | 0 | 100 | 100 | 0 |
| Provision for impaired receivables | (304) | (181) | (123) | (261) | (135) | (126) |
| Prepayments | 641 | 0 | 641 | 806 | 0 | 806 |
| Accrued income | 107 | 107 | 0 | 213 | 213 | 0 |
| PDC Receivable | 42 | 0 | 42 | 56 | 0 | 56 |
| Other receivables | 2,490 | 1,078 | 1,412 | 2,552 | 1,083 | 1,469 |
| **Total Current Trade and Other Receivables** | **6,938** | **4,966** | **1,972** | **5,527** | **3,322** | **2,205** |
| **Non-Current** | | | | | | |
| NHS Receivables | 0 | 0 | 0 | 0 | 0 | 0 |
| Provision for impaired receivables | (115) | 0 | (115) | (114) | 0 | (114) |
| Prepayments | 0 | 0 | 0 | 0 | 0 | 0 |
| Accrued income | 0 | 0 | 0 | 0 | 0 | 0 |
| Other receivables | 1,094 | 0 | 1,094 | 1,185 | 0 | 1,185 |
| **Total Non Current Trade and Other Receivables** | **979** | **0** | **979** | **1,071** | **0** | **1,071** |

## 11.2 Provision for impaired receivables

| | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| **At 1 April** | 375 | 242 |
| Increase in provision | 130 | 189 |
| Amounts utilised | (86) | (56) |
| Unused amounts reversed | 0 | 0 |
| **At 31 March** | **419** | **375** |

## 11.3 Analysis of receivables by age:

| **Ageing of impaired receivables:** | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| 0-30 Days | 0 | 0 |
| 30-60 Days | 0 | 0 |
| 60-90 Days | 0 | 0 |
| 90-180 Days | 0 | 0 |
| Over 180 Days | 2,696 | 2,618 |
| **At 31 March** | **2,696** | **2,618** |

| **Ageing of non impaired receivables:** | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| 0-30 Days | 4,279 | 3,432 |
| 30-60 Days | 510 | 276 |
| 60-90 Days | 122 | 183 |
| 90-180 Days | 505 | 347 |
| Over 180 Days | 224 | 116 |
| **At 31 March** | **5,640** | **4,354** |

## 12 Current and Non Current Liabilities

### 12.1 Trade and other payables

| | Total 31 March 2012 | Financial liabilities at 31 March 2012 | Non-financial liabilities at 31 March 2012 | Total 31 March 2011 | Financial liabilities at 31 March 2011 | Non-financial liabilities at 31 March 2011 |
|---|---|---|---|---|---|---|
| **Current** | | | | | | |
| | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| Receipts in advance | 378 | 0 | 378 | 87 | 0 | 87 |
| NHS payables | 3,535 | 3,535 | 0 | 2,838 | 2,838 | 0 |
| Amounts due to other related parties | 1,627 | 1,627 | 0 | 1,569 | 1,569 | 0 |
| Trade payables - capital | 2,043 | 2,043 | 0 | 716 | 716 | 0 |
| Other trade payables | 4,334 | 4,334 | 0 | 6,153 | 6,153 | 0 |
| Taxes payable | 2,790 | 0 | 2,790 | 2,694 | 0 | 2,694 |
| Other payables | 2,179 | 2,179 | 0 | 2,508 | 2,508 | 0 |
| Accruals | 4,219 | 4,219 | 0 | 889 | 889 | 0 |
| PDC payable | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Current Trade and Other Payables** | **21,105** | **17,937** | **3,168** | **17,454** | **14,673** | **2,781** |

Note. As part of the Whole of Government Accounting exercise the Foundation Trust was required to agree balances with other Government bodies in order to eliminate accounting treatment differences on consolidation. The classification of the Trade and other payables balances for 2010/11 has been restated as a result of this exercise.

## 12.2 Other liabilities

| | Total 31 March 2012 | Restated Total 31 March 2011 | Total 1 April 2010 |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Current** | | | |
| Deferred income | 0 | 271 | 235 |
| Deferred Government grant | 0 | 0 | 6 |
| **Total Other Current Liabilities** | **0** | **271** | **237** |
| **Non-current** | | | |
| Deferred income | 0 | 0 | 0 |
| Deferred Government grant | 0 | 0 | 16 |
| **Total Other Non- Current Liabilities** | **0** | **0** | **16** |

Note: Deferred income has been restated for 2010/11 due to the revised accounting treatment of Government granted assets. See Note 1.19 for further details.

## 13 Borrowings

| | At 31 March 2012 | At 31 March 2011 |
|---|---|---|
| | £000 | £000 |
| **Current** | | |
| Obligations under finance leases | 316 | 316 |
| **Total Other Current Liabilities** | **316** | **316** |
| **Non-current** | | |
| Obligations under finance leases | 223 | 516 |
| **Total Other Non- Current Liabilities** | **223** | **516** |

## 14 Prudential Borrowing Code

Poole Hospital NHS Foundation Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

• the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.

• the amount of any working capital facility approved by Monitor.

| | At 31 March 2012 | At 31 March 2011 |
|---|---|---|
| | £000 | £000 |
| Long term borrowing limit set by Monitor | 36,600 | 34,900 |
| Working capital facility agreed by Monitor | 13,000 | 13,000 |
| **At 31 March** | **49,600** | **47,900** |

Note: The Trust did not avail of any borrowing or working capital facility (apart from finance lease borrowing) in 2011/12 or 2010/11.

| | 2011/12 | | Restated 2010/11 | |
|---|---|---|---|---|
| | **Approved** | **Actual** | Approved | Actual |
| Minimum dividend cover | **4.4x** | **4.4x** | 2.3x | 2.3x |
| Minimum interest cover | **n/a** | **n/a** | n/a | n/a |
| Minimum debt service cover | **n/a** | **n/a** | n/a | n/a |
| Maximum debt service to revenue | **n/a** | **n/a** | n/a | n/a |

Note: The Trust's only borrowings are through finance lease arrangements as outlined in Note 13. It is therefore not considered necessary to include ratios for minimum interest cover, minimum debt service cover and maximum debt service to revenue.

## 15 Finance Lease Obligations

| | Minimum Lease Payments | | Present Value of Minimum Lease Payments | |
|---|---|---|---|---|
| | At 31 March 2012 | At 31 March 2011 | At 31 March 2012 | At 31 March 2011 |
| | £000 | £000 | £000 | £000 |
| **Gross lease liabilities** | | | | |
| **of which liabilities are due:** | | | | |
| not later than one year; | 275 | 322 | 268 | 315 |
| later than one year and not later than five years; | 296 | 576 | 271 | 515 |
| later than five years; | 0 | 0 | 0 | 0 |
| Finance charges allocated to future periods | (32) | (68) | 0 | 0 |
| **Total Gross Lease Liabilities** | **539** | **830** | **539** | **830** |
| **Net lease liabilities** | | | | |
| not later than one year; | 316 | 286 | 268 | 315 |
| later than one year and not later than five years; | 223 | 544 | 271 | 515 |
| later than five years; | 0 | 0 | 0 | 0 |
| **Total net lease liabilities** | **539** | **830** | **539** | **830** |

Note: Finance Leases relate to pharmacy and medical equipment assets.

## 16 Provisions for Liabilities and Charges

| Current | Total 31 March 2012 | Total 31 March 2011 |
|---|---|---|
| | £000 | £000 |
| Pensions relating to other staff | 34 | 33 |
| Other legal claims | 555 | 53 |
| Redundancy | 410 | 0 |
| Other | 0 | |
| **Total Current Provisions for Liabilities and Charges** | **999** | **86** |

| Non-current | | |
|---|---|---|
| | £000 | £000 |
| Pensions relating to other staff | 524 | 520 |
| Other | 0 | 0 |
| **Total Non-current Provisions for Liabilities and Charges** | **524** | **520** |

**Provisions for liabilities and charges**

| | 31 March 2012 Pensions relating to other staff | Legal claims | Redundancy | Other | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| At 1 April 2011 | 553 | 53 | 0 | 0 | 606 |
| Arising during the period | 31 | 542 | 410 | 0 | 983 |
| Utilised during the period | (40) | (18) | 0 | 0 | (58) |
| Reversed unused | 0 | (22) | 0 | 0 | (22) |
| Unwinding of discount | 14 | 0 | 0 | 0 | 14 |
| **At 31 March 2012** | **558** | **555** | **410** | **0** | **1,523** |
| At 1 April 2010 | 361 | 89 | 0 | 0 | 450 |
| Arising during the period | 229 | 54 | 0 | 0 | 283 |
| Utilised during the period | (44) | (64) | 0 | 0 | (108) |
| Reversed unused | 0 | (26) | 0 | 0 | (26) |
| Unwinding of discount | 7 | 0 | 0 | 0 | 7 |
| **At 31 March 2011** | **553** | **53** | **0** | **0** | **606** |

**Expected timing of cashflows at 31 March 2012:**

| | | | | | |
|---|---|---|---|---|---|
| Not later than one year | 34 | 555 | 410 | 0 | 999 |
| Later than one year and not later than five years | 135 | 0 | 0 | 0 | 135 |
| Later than five years | 389 | 0 | 0 | 0 | 389 |
| **Total** | **558** | **555** | **410** | **0** | **1,523** |

Legal claims relate to employer and third party liability claims against the Trust.

**Clinical Negligence Liabilities:**

£46,807k is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the NHS Trust (31 March 2011 £47,927k).

**Non Clinical Liabilities**

Note: Refer to Note 20 re Contingent Liabilities for Non Clinical claims.

## 17 Cash and Cash Equivalents

| | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| **At 1 April** | **8,969** | **4,535** |
| Net change in year | 6,389 | 4,434 |
| **Balance at 31 March** | **15,358** | **8,969** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 114 | 39 |
| Cash with the Government Banking Service | 15,244 | 8,930 |
| **Cash and Cash Equivalents as in SoFP and SoCF at 31 March** | **15,358** | **8,969** |

## 18 Contractual Capital Commitments

| | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| Property, Plant and Equipment | 3,219 | 226 |
| **Total at 31 March** | **3,219** | **226** |

## 19 Events after the Reporting Period

There were no events after the reporting period having a material effect on the accounts.

## 20 Contingent Liabilities

| | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| Gross value of contingent liabilities | (28) | (25) |
| Amounts recoverable against contingent liabilities | 0 | 0 |
| **Total Contingent Liabilities** | **(28)** | **(25)** |

The above contingency relates to the Liabilities to Third Party Scheme (LTPS) administered by the NHS Litigation Authority (NHSLA) on behalf of the Trust. The NHSLA is currently resolving a total of 20 claims made against the Trust and the above represents their view of the net amount the Trust would have to pay if cases provided for, and adjusted for probability, were to be settled in favour of the claimant.

## 21 Related Party Transactions

Poole Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Poole Hospital NHS Foundation Trust, with the exception of the contractual pay which has been disclosed in the Remuneration Report within the Directors' Report.

The Department of Health and any other body within the Whole of Government Accounts is regarded as a related party. During the year Poole Hospital NHS Foundation Trust has had a significant number of material transactions with the Department and with other entities as follows.

The Foundation Trust is anticipating similar levels of income from Bournemouth and Poole and Dorset PCTs for 2012/13 and would expect to carry out similar services for this level of income.

| | 2011/12 | | 2010/11 | |
|---|---|---|---|---|
| **21.1 Value of Transactions with Other Related Parties** | **Income** **£'000** | **Expenditure** **£'000** | **Income** **£'000** | **Expenditure** **£'000** |
| Royal Bournemouth and Christchurch NHS FT | 3,303 | 3,248 | 3,053 | 3,961 |
| Bournemouth and Poole PCT | 119,375 | 30 | 115,720 | 288 |
| Dorset PCT | 45,955 | 108 | 47,245 | 132 |
| Dorset County Hospital FT | 902 | 2,794 | 239 | 2,316 |
| Dorset Healthcare FT | 1,965 | 408 | 302 | 38 |
| South West SHA | 5,618 | | 5,783 | - |
| Bristol PCT | 4,887 | | 3,105 | - |
| Hampshire PCT | 3,685 | | 3,517 | - |
| NHS Litigation Authority | | 4,954 | - | 4,286 |
| Dept. of Health (incl. Prescription Pricing Authority) | | 1,778 | | |
| NHS Business Authority ( incl. NHS Supply Chain) | | 2,994 | - | 1,540 |
| Other NHS Bodies | 3,333 | 1,679 | 2,997 | 4,462 |
| National Blood Authority | | 1,342 | - | 1,527 |
| NHS Pension Scheme | | 12,641 | - | 12,500 |
| National Insurance Fund | | 8,883 | - | 8,685 |
| Other WGA Bodies | 241 | | - | 82 |
| **Total Value of Transactions with Other Related Parties** | **189,264** | **40,859** | **181,961** | **39,817** |

Note: The Trust paid income tax on behalf of its employees to HMR&C amounting to £17,309k (2010/11 £18,000k) and recovered net Vat amounting to £2,112k (2010/11 £2,384k). These amounts have not been included in the accounts as income or expenditure. De minimis rules apply to disclosure whereby only expenditure or income in excess of £1.0 million is disclosed.

## 21.2 Balances with Other Related Parties

| | At 31 March 2012 | | At 31 March 2011 | |
|---|---|---|---|---|
| | Receivables £000 | Payables £000 | Receivables £000 | Payables £000 |
| Royal Bournemouth and Christchurch NHS FT | 1,858 | 2,077 | 851 | 1,062 |
| Bournemouth and Poole PCT | | | 107 | 45 |
| Dorset County Hospital NHS FT | 78 | 330 | 331 | 647 |
| Dorset Healthcare | 637 | 90 | | |
| Bristol PCT | 640 | | | |
| Dorset PCT | 111 | - | 376 | 64 |
| University Hospital Southampton | 4 | 303 | | |
| NHS Pension Scheme | | 1,627 | - | 1,569 |
| NHS Business Authority ( incl. NHS Supply Chain) | | 323 | - | 316 |
| Dept. of Health (incl. Prescription Pricing Authority) | | 183 | - | 382 |
| Other NHS Bodies | 443 | 229 | 396 | 322 |
| Charitable Funds | 108 | | 32 | - |
| National Insurance Fund | | 1,352 | - | 1,237 |
| HMR&C | 243 | 1,438 | 171 | 1,457 |
| Other WGA Bodies | 56 | | 58 | 5 |
| Forest Holme | 27 | | 10 | - |
| **Total Balances with Other Related Parties** | **4,205** | **7,952** | **2,332** | **7,106** |

De minimis rules apply to disclosure whereby only debtor or creditor balances in excess of £0.1 million are disclosed.

## 22 Private Finance Transactions

### PFI schemes deemed to be off-SoFP

### Re Staff Residences

£246k (£280k 2010/11) is included within operating expenses in respect of PFI transactions deemed to be off SoFP.

The Trust is committed to make a payment of £109k during the next year in respect of a PFI scheme that is expected to expire in approximately 9 years.
The estimated capital value of the PFI scheme is £3.5 million.
The scheme started on 1 April 1996 and is contracted to end on 31 August 2021.

Western Challenge Housing Association acquired the staff residences from the Trust in September 1996 on a 99 year lease with a break clause after 25 years. The Trust is committed to pay £28k rent subsidy per annum (fixed through the period of the lease) and also a management fee of £56k (increased annually by the Retail Price Index) for the duration of the lease.

**Re: Nursery**

£30k (£30k 2010/11) is included within operating expenses in respect of PFI transactions deemed to be off SoFP.

The Trust is committed to make a payment of £30k during the next year in respect of a PFI scheme that is expected to expire in approximately 7 years.
The estimated capital value of the PFI scheme is £0.4 million.
The scheme started on 1 September 2004 and is contracted to end on 31 August 2019.
The Trust entered (in August 2004) into a 15 year lease with BDL Systems Ltd. Retirement Benefit Scheme In respect of the rental of a building at Denmark Lane, Poole for the purpose of providing a nursery, mainly for Poole Hospital staff. The nursery is managed by TOPS Day Nursery. The Trust leased back the building to TOPS on the same terms and conditions as the original lease. The Trust will pay BDL Pensions Limited a sum of £30k per annum for a period of 15 years. TOPS will pay a similar amount to the Trust over the same 15 year period.

## 23 Financial Instruments

Financial reporting standard IFRS7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which the financial reporting standards mainly applies. The NHS Foundation 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 NHS Foundation Trust in undertaking its activities. Refer to Note 14 re the Prudential Borrowing Code.

The Foundation Trust's financial assets and liabilities are valued at amortised cost and these are the only type of financial instrument held.

**Market Risk**

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. Market risk comprises three types of risk, where the fair value or future cash flows could fluctuate because of movements in the underlying Interest rate risk, Currency risk; and Price risk

*Interest rate risk:*

The Foundation Trust invests surplus funds with major UK banks and building societies. There were no short term investments held at the year end. Therefore the Foundation Trust's financial assets and liabilities carry nil or fixed rates of interest and the Foundation Trust's income and operating cash-flows are substantially independent of changes in market interest rates.

*Currency risk*

The Foundation Trust's transactions are all undertaken in sterling and so it is not exposed to foreign exchange risk.

*Price risk*

The Foundation Trust has got a number of contractual arrangements which are linked to the UK Retail Price Index (RPI). As such the Foundation Trust is exposed to price risk in line with movements in the UK economy.

**Credit Risk**

Credit risk is the possibility that other parties might fail to pay amounts due to the Foundation Trust. Credit risk arises from deposits with banks as well as credit exposures to the Foundation Trust's debtors. The Foundation Trust's cash assets are held with Barclays Bank plc and the Government Banking Service (GBS). Additionally the Foundation Trust has invested surplus cash with an approved panel of major UK banks and building societies during the year. The panel of banks used has complied with Monitor's strict criteria for investments.

As set out in Note 17 - £15,244k (31 March 2011 £8,930) of the Trust's cash deposits is held with the Government Banking Service (GBS). At the end of the financial year there were no sums held in the form of short term investments (2010/11: £nil).

An analysis of the ageing of receivables and provision for impairment can be found at Note 11.1 "Receivables". The majority of the outstanding debt relates to other NHS bodies, related parties and the CRU in respect of RTA income. Receivables from other NHS bodies and related parties is considered to be fully recoverable. A bad debt provision of 10.5% (2010/11 9.6%) is made against the CRU (RTA income) receivables.

**Liquidity risk**

The NHS Foundation Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Foundation Trust also largely finances its capital expenditure from funds generated from its activities. Capital commitments at 31 March 2012 amounted to £3,219k (£226k at 31 March 2011) - see Note 19 and Finance Lease commitments amounted to £539k (£832k at 31 March 2011) - see Note 13. The NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

## 24 Financial Assets and Liabilities by Category

Set out below are the NHS Trust's financial assets and liabilities as at 31 March 2012.
There are no material differences between the book value and fair value.

| | Loans and Receivables | |
|---|---|---|
| | **31 March 2012** | 31 March 2011 |
| | **£000** | £000 |
| **Financial assets** | | |
| Cash | **15,358** | 8,969 |
| Current Asset Investments | **0** | 0 |
| NHS Receivables | **3,771** | 2,061 |
| Accrued Income | **107** | 213 |
| Other Receivables | **1,088** | 1,047 |
| **Total** | **20,324** | **12,290** |

The following are not considered to be financial instruments and therefore have been excluded from the above table:
- The NHS Injury Cost Recovery Scheme amounting to £2,276k (2010/11 £2,243k).
- Prepayments amounting to £641k (2010/11 £806k).
- PDC receivable amounting to £42k (2010/11 £56k).
- Vat recoverable amounting to £243k (2010/11 £171k).

| | Other Financial Liabilities | |
|---|---|---|
| | | Restated |
| | **31 March 2012** | 31 March 2011 |
| **Financial liabilities** | | |
| **Trade and Other Payables** | | |
| NHS Payables | **3,535** | 3,869 |
| Accruals | **4,219** | 889 |
| Capital Payables | **2,043** | 716 |
| Other Payables | **8,140** | 9,199 |
| **Total Trade and Other Payables** | **17,937** | **14,673** |

| | | |
|---|---|---|
| **Other Financial Liabilities** | | |
| Finance Lease obligations (Note 1) | **539** | 830 |
| Provisions under contract (Note 2) | **558** | 553 |
| **Total Other Financial Liabilities** | **1,097** | **1,383** |
| **Total** | **19,034** | **16,056** |

The following are not considered to be financial instruments and therefore have been excluded from the above table:
- Deferred Income amounting to £0k (2010/11 £271k).
- Other Tax Payables amounting to £2,790k (2010/11 £2,694k).
- Provisions not under contract amounting to £965k (2010/11 £53k).
- Receipts in Advance amounting to £378k (2010/11 £87k).

Note 1 - Fair value is not significantly different from book value, in the calculation of book value, the expected cash flows have been discounted by the discount rate of 6.0% in real terms.

Note 2 - Fair value is not significantly different from book value, in the calculation of book value, the expected cash flows have been discounted by HM Treasury pension discount rate of 2.8% (2010/11 2.8%) in real terms.

## 25 Third Party Assets

The Trust held £3k cash at bank and in hand at 31 March 2012 (£11k - at 31 March 2011) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

## 26 Losses and Special Payments

There were 258 (176 cases 2010/11) cases of losses and special payments totalling £182k (restated £168k 2010/11) during the period 1 April 2011 to 31 March 2012.

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