Poole Hospital NHS
NHS Foundation Trust

# Annual report and accounts 2012/13

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ANNUAL REPORT & ACCOUNTS 2012/13



# Welcome

Welcome to Poole Hospital NHS Foundation Trust's annual report for 2012/13, which presents an overview of the trust's performance during the financial year.

Our enduring focus throughout 2012/13 was the quality of the care we provide to our patients. We continued to embed our Golden Rules, which provide simple 'back to basics' steps designed to help us get it right for every patient every time, and introduced a range of initiatives and improvements to further enhance our patients' experience.

New bathroom facilities were installed to support patients' privacy and dignity; a £250,000 project was completed to refurbish one of our elderly care wards using dementia-friendly design principles; our 'mealtime companion' scheme continued to offer support to patients in need; and a new 'finger food' menu was introduced to encourage patients with smaller appetites to eat whilst in hospital.

The importance of getting these and many other basics right was underlined in February 2013, when the final report of the public enquiry into Mid Staffordshire NHS Foundation Trust, the 'Francis' Report, was published. The report emphasised the importance of organisational culture in putting patients first, and its recommendations have been scrutinised by our board of directors to ensure we are doing all we should for our patients.

Poole Hospital has a unique and well established philosophy of care, the Poole Approach, which states that we will strive to provide 'friendly, professional, patient-centred care with dignity and respect for all'. The values embedded in both this and the Golden Rules support a culture committed to putting patients first, but we will be working with staff over the coming months to ensure their views on this are also heard and implement any actions required following the Francis Report's recommendations.

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We were extremely pleased during the year to see the quality of care at Poole recognised in several major patient surveys including the National Cancer Patient Experience Survey, which ranked the care at Poole amongst the best in the country, and the National Adult Inpatient Survey, which was published just after the end of the financial year and rated Poole the best acute hospital in Dorset.

The hospital adopted new techniques and technology during 2012/13 which placed us at the forefront of care in some key clinical areas. The introduction of RapidArc radiotherapy technology led to greater accuracy of treatment for cancer patients, and the opening of a powerful 3T MRI scanner – one of only two in the region – means state-of-the-art imaging and whole-body scanning is now possible at Poole Hospital.

Against a changing NHS landscape, staff across the hospital showed continuing commitment and initiative during 2012/13, and the trust delivered cost-savings of £3.3 million over the course of the year and delivered against its key financial targets. However, in spite of this positive performance, the trust continues to face significant financial challenge over the coming years, with substantial savings required and an increasingly limited scope to find them.

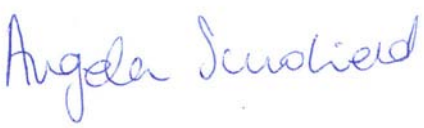
The proposed merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust presents a means of sustaining and improving hospital services for the local community, allowing us to achieve far greater financial resilience whilst providing a range of opportunities to enhance and develop care, including more consultant-delivered care 24 hours a day, seven days a week and the building of a new high-tech maternity hospital.

Work has therefore continued during 2012/13 to progress towards a merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The case for the proposed merger was reviewed by the Office of Fair Trading in late 2012 and subsequently referred to the Competition Commission in January 2013. We currently await the outcome of the Competition Commission's review.

We were delighted to hear in March 2013 that Poole Hospital matron Geoffrey Walker had been named Nurse of the Year in a prestigious national awards scheme. The British Journal of Nursing magazine handed Geoffrey the award in recognition of the outstanding contribution he has made to patients in Poole over 25 years of nursing, with judges commenting that 'his dedication to nursing goes above and beyond all expectations'.

Finally, we would like to pay credit to our council of governors and the essential role they play within the trust. Our governors form a vital link between the hospital and the local community, and have worked extremely hard throughout the year to ensure the views of our members are heard and represented. Thank you to them all.

**Chris Bown, chief executive**



**Angela Schofield, chairman**

# Directors' report

## Important information about our trust from the board of directors

Poole Hospital became an NHS foundation trust on 1 November 2007 under the National Health Service Act 2006. NHS foundation trusts are not-for-profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital, mental health and ambulance services. They were created to devolve decision making from central government to local organisations and communities. They provide and develop healthcare according to core NHS principles – free care, based on need and not ability to pay.

Foundation trusts are regulated by Monitor whose main duty is to protect and promote the interests of patients. 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 gives strategic leadership to the trust and develops 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 on the board of directors and council of governors can be found in the governance and membership section of the annual report on page 53.

**Our maternity staff delivered over 4,750 babies during 2012/13**

## About the trust

Poole Hospital NHS Foundation Trust is an acute general hospital with 621 beds, 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, such as child health and maternity, for a wider catchment area, including Bournemouth and Christchurch. In addition, the hospital provides specialist services such as cancer care to patients from across Dorset.

At the end of 2012/13, Poole Hospital employed 3,062 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 over £200m. During this time we gave care to:

- **46,417** inpatients, including maternity
- **27,563** day patients
- **70,068** new outpatients
- **118,594** follow-up outpatients
- **59,961** patients attending our emergency department
- **4,758** babies delivered by our maternity staff

Our vision is to provide excellent patient-centred emergency and planned care to the people we serve, and the hospital has a unique philosophy which underpins that care. The Poole Approach pledges that we will strive at all times to 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 and submit an annual report and accounts. The Act lays down three main statutory requirements for an NHS foundation trust in relation to its accounts:

1. To keep proper accounts and proper records in such form as the regulator may, with the approval of the Secretary of State, direct
2. To prepare in respect of each financial year annual accounts in such a form as the regulator may, with the approval of the Secretary of State, direct
3. To comply with any directions given by the regulator with the approval of the Secretary of State as to the methods and principles according to which the accounts are to be prepared; and the content and form to be given in the accounts

In determining the form and content of the annual accounts, Monitor, as the regulator, must aim to ensure that the accounts present a true and fair view and comply with International Financial Reporting Standards.

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

**We are committed to providing friendly, professional, patient-centred care**

## Highlights of the year

The year's highlights included the implementation of new state-of-the-art technology, initiatives to help patients safely leave hospital sooner and excellent performance in several national surveys:

### New powerful MRI scanner installed

Poole Hospital now offers one of the most powerful MRI scanners available for clinical use, following the installation of the Philips Ingenia 3T MRI scanner in August 2012. It is one of only a handful of 3T MRI scanners in England, twice as powerful as the more common 1.5T scanners found in most hospitals. It is only the second such scanner in the south west.

Its increased scanning power enables the most detailed imaging ever possible at Poole Hospital. It can also produce conventional quality images faster than

a 1.5T MRI scanner, and offers a more comfortable experience for patients thanks to its wide bore. The opening of the new scanner now enables the hospital to offer whole body scans which can identify the spread and prevalence of cancer.

## Dementia-friendly ward design

In spring 2012, Poole Hospital's Lulworth Ward reopened its doors to patients following a major refurbishment project. Supported by The King's Fund's 'Enhancing The Healing Environment' programme, the project was carried out to improve patients' wellbeing and benefit those with dementia during disorientating hospital stays.

Lulworth Ward is an acute medical ward caring for older people, many of whom have a cognitive impairment such as dementia. The new design was developed based on research into how the environment can support health and wellbeing, and aid orientation and independence for people with dementia. Every key element of the environment was considered, from the lighting and colour of the walls to the use of art and signage.

## Cancer care amongst the best in the country

The standard of care for cancer patients at Poole Hospital was rated amongst the best in the country in the 2011/12 National Cancer Patient Experience Survey. The survey found that 94% of patients rated their care as 'excellent' or 'very good', giving Poole the highest score recorded amongst trusts.

**Lulworth Ward was refurbished to benefit patients with dementia**

In 40 out of 70 questions asked (57%), the responses from patients regarding their care at Poole Hospital were in the highest scoring 20% of all trusts in the country; none were in the lowest scoring 20%. Patients rated Poole Hospital particularly highly in areas including:

- Good access to, and support given by, cancer nurse specialists
- Good quality consultations and management of patient contact by hospital doctors
- Good standard of communication, understanding and support by ward nurses
- Patients expressed a high level of confidence in the staff caring for them and reported being treated with respect and dignity.
- Good quality information given to patients at discharge
- Overall care

## Poole matron is named national Nurse of the Year

Poole Hospital matron, Geoffrey Walker, was named Nurse of the Year in a prestigious national awards scheme. The British Journal of Nursing magazine handed Geoffrey the award in recognition of the outstanding contribution he has made to patients in Poole over more than 25 years of nursing. Judges described the matron, responsible for medicine, cardiology and specialist nursing services, as "a clear winner."

Geoffrey's nomination cited the role he played in establishing Poole Hospital's cardiology patient support group - now in its tenth year - and the creation and development of the medical

"Poole received the highest recorded score for overall standard of care in the National Cancer Patient Experience Survey"

investigations unit (MIU), both at Poole Hospital. Julie Smith, British Journal of Nursing editor and a judge of the category, said: "His dedication to nursing goes above and beyond all expectations, and his passion for excellence in nursing and developing and improving patient care is unmatched. It is nurses like Geoffrey who restore our faith in the profession and we are absolutely delighted to have awarded him BJN Nurse of the Year 2013.'

### New private patient suite opens to boost income for NHS care

Poole Hospital officially opened a new suite for private patients in October 2012. The Cornelia Suite offers private patients a dedicated suite of rooms within the hospital and has been launched with the aim of generating additional income to reinvest into care for NHS patients.

The new facility contains six private rooms, all with en-suite facilities, and is located on the fifth floor of the hospital, offering patients spectacular views of Poole and the harbour. Designed with comfort in mind, the rooms provide an exclusive facility for private patients, but with the experience and expertise of an established NHS hospital on-hand.

The hospital offers private patients access to a wide range of inpatient and outpatient services, including diagnostic tests such as x-rays and scans, cardiology, radiotherapy and chemotherapy, orthopaedic care, endoscopy, gynaecology and a range of surgical options.

### Initiative with Red Cross gets patients home sooner

A new service at Poole Hospital is helping elderly or vulnerable patients avoid an overnight stay by giving them the confidence and support they need to return home safely. The ground-breaking assisted discharge service is a joint initiative between the hospital and The Red Cross in Dorset. The charity provides skilled staff and volunteers to assist patients who are referred to the service via the emergency department or the Rapid Access Consultant Evaluation (RACE) unit.

From providing transport from hospital to

ensuring lights and heating are on at the other end, the assisted discharge scheme seeks to ensure patients – who may be isolated or vulnerable, or whose relatives are unable to take them home – are comfortable and confident once home. It is the only scheme of its type in the county.

Val Horn, Poole Hospital's matron for older people, helped establish the initiative: "Some patients who attend hospital do not require an inpatient stay," she explained. "This scheme is about supporting those patients, where appropriate, to be independent and confident in their own homes. Such patients could more beneficially continue their recovery at home rather than in hospital. We discussed this with The Red Cross and together created a completely new service for patients - the feedback from those that have used it so far has been absolutely fantastic."

## Improving care for medical patients

Medical wards and departments have been reorganised to support improvements to patient care and streamline services at Poole Hospital. The changes include an expansion of the medical investigations unit (MIU), which now includes the relocated and enlarged discharge lounge, and the creation of newly laid out medical wards. Patients on the new wards will benefit from enhanced privacy provided by an increase in side rooms with en-suite facilities, while the number of beds also increases.


**The hard-working team on our flagship medical investigations unit (MIU)**

The expansion of the nurse-led MIU means more patients have access to day case treatment from nurse prescribers, who are responsible for providing a number of treatments, including administering intravenous antibiotics and drug infusions, biopsies, blood transfusions and PICC line insertions.

Poole Hospital's MIU is one of the few across the UK led entirely by specially trained nurses, who assess patients with diagnosed or undiagnosed conditions and make decisions about the clinical care they need, including prescribing medication. In June 2012, nurses in MIU became among the first in England to prescribe blood and blood products on a non-emergency basis – a service previously delivered by doctors.

## New radiotherapy equipment means greater accuracy of treatment

Prostate cancer patients at Poole Hospital are the first in Dorset to benefit from innovative radiotherapy treatment.

The new RapidArc technology allows cancer specialists to pinpoint the location of a tumour with greater accuracy, accounting for its movement within the body, reducing side effects and increasing cure rates.

Mike Bayne, clinical director for oncology services at Poole Hospital, said. "For the first time in Dorset we can deliver precision radiation therapy treatments two to eight times faster than traditional methods. By leaving less time for tumour motion during dose delivery, the radiation dose can concentrate on doing what it does best – killing cancer cells."

Two of the trust's four linear accelerator (linac) machines now incorporate the latest technology – Image Guided Radiotherapy (IGRT), which pinpoints the position of a tumour within patients immediately prior to treatment, and Intensity Modulated Arc Therapy (IMAT) which allows dose distribution to be shaped to cover the tumour, meaning higher doses can be given more accurately in a faster time.

**The trust's clinical director for cancer Dr Mike Bayne showcases the new RapidArc radiotherapy technology**

## Hospital is 'better performing' nationally in range of areas

Findings from a major national patient survey show that Poole Hospital continues to perform strongly for patients. The national inpatient survey, published on 16 April 2013, saw more than 400 patients who had been admitted to Poole Hospital complete the detailed questionnaire.

Their responses paint a healthy picture of high quality care, confidence in ward staff and respect for patient privacy and dignity. The Care Quality Commission report, which was conducted from September 2012 to January 2013, found the hospital to be better performing than most trusts nationally in a range of areas, including:

- Privacy in A&E
- Time spent waiting for a bed on a ward
- Support to eat and drink at mealtimes
- Nurses giving understandable answers to important questions
- Confidence and trust in nursing staff
- Privacy when being treated or examined

No areas were rated as 'worse performing' nationally.

The survey also found areas in which performance could be strengthened, including ensuring the views of patients about the quality of their care is sought, making information on how to complain clearer and the number of occasions in which an operation or procedure's date was changed. Patients also highlighted the use of mixed sex accommodation and bathroom facilities.

The trust has worked through the report in detail to understand where we can improve, and has already implemented changes in some important areas, including tackling the issue of accommodation and bathroom facilities. Since the survey was undertaken, refurbishment of accommodation on our wards means all medical inpatients can now be accommodated in single sex, en suite rooms and bays.

Our emergency assessment unit has also undergone extensive refurbishment and now provides twice the number of single rooms than previously possible. We also offer bathroom facilities which can be designated as either for male or female use exclusively, and will never ask men and women to share bathroom facilities at the same time.


Poole Hospital NHS
WELCOME TO POOLE HOSPITAL – CATERING SERVICES
DOLPHIN RESTAURANT
DIET



# Business review

## A review of the year's clinical and financial performance

Poole Hospital's commitment to improving patients' experience was reflected in strong performance during 2012/13. The trust achieved or exceeded most of the targets set down by Monitor, the regulator of foundation trusts, and maintained steady financial and clinical performance within a challenging and changing climate.

This was achieved through the daily hard work of staff across all aspects of clinical care, administration and management.

Throughout the year staff concentrated their efforts on ensuring we delivered high-quality care in all clinical areas including front door, ambulatory and short stay services, inpatient care and outpatient areas.

### Patient experience

The trust continued to deliver strong performance against the majority of key Monitor targets for access to care and waiting times, as well as the targets set by the local primary care trust.

The 18-week referral-to-treatment standard was achieved for admitted, non-admitted patients and incomplete pathways in every month of the year, and key targets for general trauma, fractured neck of femur (hip) surgery and stroke care were also achieved. In all these areas a steady improvement was seen throughout the year. All quarterly targets for access to cancer treatment were also met.

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Substantial work to reduce waits for endoscopy treatment led to significantly improved performance by the end of the year, and no patients were waiting in excess of six weeks for an endoscopy procedure by the end of March 2013.

The hospital's emergency department (ED) continued to see high attendances throughout the year, but staff at the frontline and behind the scenes worked hard to keep waiting times down, and the target for a maximum four-hour wait was met in 11 out of 12 months. However, March 2013 saw an exceptional rise in activity (over 5% more attendances than the same period in 2012) combined with additional challenges in terms of presentation patterns. As a result, the quarterly Monitor target was narrowly missed, with 94.85% of patients waiting under four hours against a target of 95%.

Work has continued throughout 2012/13 to improve the management of patients in ED, with steady and demonstrable improvements over the year. This work will continue and we are already acting on the learning gained during the pressurised period in March, focusing in particular on the pathways for patients who need to be transferred for inpatient care.

The trust maintained its positive track record for the control and prevention of hospital-acquired infections during the year. A small rise in cases of c-difficile in early 2013 resulted in a total of 27 cases over the year against a target of 25, and four cases of MRSA were also reported during the year. These figures remain low compared to national averages, but steps have been taken to ensure the hospital's robust infection control measures are upheld, and that we are doing all we should to protect our patients from infection.

**The hospital has robust hand hygiene measures in place**

## Improving the way we deliver care

A range of initiatives were implemented during 2012/13 to further enhance our patients' experience and develop the way we deliver care.

We continued to improve the way patients move through their clinical pathways so that delays in treatment are minimised, and the key focus revolves around 'right patient, right bed, right care' and 'a plan for every patient every day'.

This work involved a wide range of initiatives including further improvements to the operational system for daily management of the trust, the development of discharge co-ordinators, further development of seven-day working, the deployment of therapies into our assessment units and a general push to reduce internal delays to treatment.

We continued to work towards minimising unnecessary length of stay by expanding the use of ambulatory and day care, keeping a key focus on short-stay care to ensure patients can return home from hospital as soon as possible, whilst also improving the efficiency of our inpatient services.

To support this we continued our close partnership working with colleagues in primary and social care services. This has led to a significant reduction in

Image kindly supplied by UNP/BRC

"We have achieved a significant reduction in delayed discharges, allowing more people to return safely home sooner"

delayed transfers of care, allowing more people to leave hospital sooner with the right support, and helping patients make careful choices about onward care in residential and nursing homes.

The trust also introduced a number of changes to the configuration of the elderly care and medical wards in early 2013. New en-suite bathroom facilities were added to all bays in our elderly care wards to support patients' privacy and dignity, and beds were reconfigured across the medical and elderly wards to provide a more intuitive layout and allow staff to manage care more effectively. We have also refurbished our emergency assessment unit (Ansty) to create additional cubicle space and improve the overall layout.

This reconfiguration of beds also provided capacity to further enhance our flagship medical investigations unit (MIU) and create an improved discharge facility. The new discharge area enables patients who are due to be discharged to move out of ward beds earlier in the day, into a unit totally focused on making their discharge safe, well organised and smooth. This also releases beds earlier in the day for new emergency patients and allows ward staff to concentrate on their presenting care needs.

As a result of the development of MIU and other initiatives, the trust has seen a significant increase in 'day patients', with 14% more patients cared for without an overnight stay in 2012/13 compared to the previous year.

A key challenge to performance and delivery of services during the year was our ability to recruit suitably trained and skilled staff, particularly on inpatient wards. The trust welcomed some excellent new staff over the year, but we have continued to develop our recruitment strategy to ensure we are always able to make new appointments efficiently when staff leave. We faced particular challenges in ensuring we have a good supply of flexible/bank staff to fill gaps in rotas at short notice, but we have recently seen a steady increase in vacancies being filled and bank staff being available.

## What our patients said

The quality of patient care at Poole Hospital was reflected in strong performance in three major national patient surveys.

The standard of care for cancer patients was rated amongst the best in the country in the National Cancer Patient Experience Survey, published in August 2012. The survey found that 94% of patients rated their care as 'excellent' or 'very good', giving Poole Hospital the highest score recorded amongst participating trusts.

In December 2012, patients using our emergency department rated the hospital highly for care and quality of treatment in a survey conducted by the Care Quality Commission. The emergency department performed strongly in many areas including patients reporting they were treated with dignity and respect, patient privacy, confidence in staff and patients waiting less than an hour to speak to a nurse or doctor. The hospital achieved 'average' or 'better than average' in comparison with other hospitals on all of the categories considered as part of the survey.

The results of the 2012 national Adult Inpatient Survey painted a similarly positive picture. The survey was conducted from September 2012-January 2013 and published in April 2013, and found the hospital to be 'better performing' in a range of important areas including time spent waiting for a bed on a ward, confidence and trust in nursing staff, and privacy when being treated or examined.

## Service improvement

The service transformation team played a key role in supporting the work required for the proposed merger during 2012/13, assisting in the coordination of key-stage deliverables for the development of the cost improvement plans (CIPs) required to support the trusts' submission to Monitor.

In addition, the service transformation team project-managed the delivery of several high-profile projects for the trust including the maternity information system, e-rostering, piloting order communications to primary care and a review of patient transport arrangements.

The team also continued to support the provision of training to trust staff during

2012/13, including the continuation of Lean training to foundation level accreditation. A management training programme was developed and implemented to support the organisation as it progressed towards the proposed merger, and this was well attended by clinical and non-clinical managers, covering topics such as change management, business case development and how to lead improvement projects.

## Quality standards

The year 2012/13 was one of excellent achievement against key quality measures, and the hospital maintained the highest standards in the fundamentals of care, including patient nutrition and the prevention of falls.

The quality report on page 85 contains more detailed information on our performance against key improvement measures covering readmissions, delayed discharges, infection prevention, A&E waits and the number of patients receiving care in the right place, at the right time. The report also highlights a range of initiatives that have supported our continued commitment to quality of care and sets out areas for improvement in the coming year.

The continued work of the clinical advisory group (CAG) has provided robust clinical management 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.

## Financial performance

Poole Hospital maintained a steady financial risk rating of 3 from Monitor throughout the year and delivered against its financial targets to end the year with a cash balance of £15m and a year-end surplus of £1.3m before the impact of estate revaluation. However, the trust continues to face significant challenges in future, caused in large part by the hospital's unique case mix, which is heavily skewed to non-elective (unplanned) care, and the way in which hospital care is now funded.


**The quality of our staff was reflected in strong performance in several national patient surveys**

Work has therefore progressed throughout the year on the proposed merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, which we anticipate will bring about significant financial savings and provide an opportunity to enhance and develop hospital services for the local population.

## Regulatory ratings

To ensure NHS foundation trusts remain well governed, financially viable and legally constituted after authorisation, hospital trusts are regularly assessed

and monitored by the independent regulator of foundation trusts, Monitor. Monitor uses 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. A financial risk rating of 3 (on a scale of 1 to 5, with 5 being the best) is regarded as acceptable and doesn't highlight significant risk of financial failure. Similarly a score of amber-green or green represents an acceptable governance rating.

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 its financial performance. As a result of this improvement, Monitor confirmed in January 2012 that the trust was now fully compliant with the terms of its authorisation.

This improvement has been maintained into 2012/13. The trust reported a steady financial risk rating of 3 throughout the year and maintained a governance risk rating of green for performance in the first three quarters of the year.

The significant pressures faced by the hospital during the final months of the year led to a governance risk rating of amber/red for quarter 4. This was as a result of performance against targets for ED and C-difficile, both of which were narrowly missed. Work is now underway at board level to identify and implement actions needed to address this. The following table shows Monitor's risk rating of the trust for 2011/12 and 2012/13:

## Our regulatory ratings

| | 2011/12 | | | | 2012/13 | | | |
|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **Financial risk rating** | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **Governance risk rating** | Red | Red | Amber/red | Amber/green | Green | Green | Green | Amber/red |

## Progressing with a plan to merge

The board of directors remained firmly committed to the proposed merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust during the year, and significant work took place to move forward with plans to merge.

A public consultation on the proposed governance arrangements for the merged trust was completed in April 2012 – you can read more about this on page 50.

In July 2012, following an independent appointment process involving governors from both organisations, the proposed board of directors for the new trust was announced. Proposed appointments to the board are made to support the planning process and ensure a smooth transition of responsibility if the merger proceeds.

The members of the proposed board are:

**Chairman:**
Jane Stichbury

**Non-executive directors**:
David Bennett
Michael Mitchell
Pankaj Davé
Steven Peacock
Alex Pike
Angela Schofield
Nick Ziebland

**Chief executive:**
Tony Spotswood

**Executive directors:**
Karen Allman, director of human resources
Mr Robert Talbot, medical director *
Stuart Hunter, finance director
Helen Lingham, chief operating officer
Richard Renaut, director of strategy
Paula Shobbrook, director of nursing
Mary Sherry, director of integration and benefits realisation **

* Mr Robert Talbot was appointed to the proposed board in September 2012 following a decision by Dr Mary Armitage to retire

**In December 2012, Mary Sherry, chief operating officer at Poole Hospital, was appointed to the post of director of integration and benefits realisation

The council of governors of the new merged organisation will be required to approve the appointment of the chairman, non-executive directors and the chief executive, should the merger be authorised.

### Competition inquiry process

In November 2012, following the enactment of the Health and Social Care Act 2012, the Office of Fair Trading announced that it would be reviewing the case for the proposed merger of Poole Hospital and the Royal Bournemouth and Christchurch Hospitals, in accordance with its new role in assessing the competition aspects of foundation trust mergers.

The Office of Fair Trading completed its review in January 2013 and subsequently referred the case to the Competition Commission. Work took place in the remaining months of the financial year to answer enquiries from the Competition Commission and present a strong case on the clinical and financial benefits of merger. At the time of writing this annual report, the Competition Commission inquiry was ongoing.

## Going concern

The board is required to formally consider whether it regards the trust as a 'going concern' as part of the annual accounts process. The board of directors has concluded that it is appropriate to prepare the accounts on a going concern

basis as a result of the following evidence:

### Compliance with authorisation:

- The trust is in full compliance with its authorisation having been released from significant breach in January 2012
- The trust has achieved a governance rating of green for 3 of the 4 quarters in 2012/13.

### Financial results 2012/13:

- The trust has achieved an operating surplus for the year to March 2013 of £1.3m before the impact of revaluation of the estate and is forecasting a small surplus for the year to March 2014
- The trust has maintained a healthy liquidity position with cash balances of £15m at the end of the year
- The trust has achieved a financial risk rating of 3 for each quarter during 2012/13.

### Financial forecast 2013/14 and beyond:

- The trust has agreed a contract with its main commissioners for 2013/14 which will provide a net recurring increase in contract income of £6.4m despite tariff reductions, representing a real growth of up to £9m. This contract should allow the trust to achieve a small surplus in 2013/14 based on current forecasts and delivery of a cost improvement programme of £4m
- The outline capital programme for 2013/14 totals £10m. This can be funded whilst maintaining cash balances at March 2014 above £10m
- Although the first quarter of 2014/15 will see further financial pressures as a result of the national 4% efficiency requirement (approximately £2m per quarter) the trust has adequate forecast cash reserves (£10m at March 2014) to maintain going concern status for at least 12 months from June 2013.

### Proposed merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

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 foundation trust which would be formed following the merger.

## Audit information

As far as each individual director of Poole Hospital NHS Foundation Trust is aware, there is no relevant audit information of which the foundation trust's auditor is unaware. Each director has taken all of the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the foundation trust's auditor is aware of that information.

The board of directors has approved a policy for the provision of any non-audit service that might be provided by the trust's external auditor. This policy removes any unnecessary restrictions on

the purchase of services from the external auditor but ensures that any non-audit service provided by them cannot impair or cannot be seen to impair the objectivity of their opinion on the Financial Statements.

The trust's current auditors, Deloitte, were appointed in October 2012 and did not provide any non-audit services to the trust during the year to March 2013. The trust's previous auditors PwC were commissioned to provide consultancy services to the trust and to The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust as part of the planned merger. However these services were commissioned after completion of the 2011/12 audit in May 2012 and with the full knowledge of the trust's audit and governance committee.

## Relationships

Poole Hospital has enjoyed excellent working relationships with each of its two main commissioning primary care trusts (PCTs), NHS Bournemouth and Poole and NHS Dorset. During 2012/13 they worked together as a single commissioning organisation to commission services for both populations. These two trusts together accounted for over 88% of the trust's income from activities during the year.

From April 2013 these primary care trusts will no longer exist and the new Dorset Clinical Commissioning Group (CCG) will be the trust's main commissioners. The CCG covers the same geographical area as the two PCTs it replaces. The relationships already established will help to ensure the continuation of excellent working relationships into the future.

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. The trust aims to use its links with the university to becoming a university hospital in the near future.

This will help to support the delivery of high-quality services through a culture of excellence, where learning, practice development and research are actively encouraged.

Each of the three local authorities, the two PCTs and Bournemouth University have had an appointed governor to the council of governors during 2012/13.

The trust has worked closely with the Royal Bournemouth and Christchurch hospitals for many years and the two trusts are working towards a proposed merger (turn to page 23 for more on this). The two trusts provide largely complementary services to the populations of Poole and Bournemouth.

The trust also enjoys close working relations with other NHS organisations, the voluntary sector and our local politicians.



# Looking ahead

## Anticipated developments and the factors affecting our future work

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.

To ensure we continue to provide high-quality, safe services Poole Hospital NHS Foundation Trust agreed investments for 2013/14 including:

- Maternity and neonatal intensive care unit investment to improve the building environment
- Ongoing refurbishment of wards and departments
- Improvements in IT to support delivery of patient care
- Endoscopy suite refurbishment
- Replacement of medical equipment

### A healthy future

Poole Hospital's board of directors is fully committed to progressing the proposed merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH). The merger offers a unique opportunity for the two foundation trusts to improve standards of care in a number of key clinical areas, and increase financial resilience.

The proposed merger will allow the trusts to deliver improved medical staff cover in all key areas. In so doing, the hospitals will improve patient outcomes, and reduce patient morbidity and mortality. It is therefore vital that the merger proceeds, to deliver these important patient benefits.

The merger also provides the only credible opportunity for the hospitals to achieve viable scale in a number of services which have traditionally operated with undesirably low patient volumes. This will deliver significant clinical and economic benefits.

Furthermore, the merger will allow both trusts to achieve significant savings by releasing important synergies and efficiencies. The trusts will be in a position to deliver substantial savings and prevent the anticipated financial failure of Poole Hospital in future years and serious financial difficulties anticipated at RBCH.

It will create a financially viable organisation able to withstand changes in tariffs, by bringing together two largely complementary trusts, one with a focus on elective care (RBCH) and one with a focus on non-elective care (Poole Hospital). The proposed merger will also allow the merged trust to implement an ambitious investment plan including the building of a new maternity unit in Poole.

It is currently anticipated that, should the merger be approved by the Competition Commission and Monitor, it will be in place by April 2014.

## 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.
- 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.
- The NHS needs to do more with less. The small annual 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 College 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.
- There is a 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

- After detailed investigation, supported by external advisors, the trust's board have concluded that Poole Hospital faces significant financial challenges in the future without the proposed merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The trust is unlikely to be financially viable beyond 2014/15 as a standalone trust. The hospital has an unusual case mix heavily skewed to non-elective care which is expensive to provide, poorly remunerated and difficult to manage in volume.
- To compound these difficulties, the hospital is located in a region with a greater and increasing proportion of older patients compared to the UK average, which presents particular challenges for the local health economy. These challenges are felt across the region but leave Poole Hospital particularly exposed because of its unusual case mix.
- The hospital's management has addressed these challenges as a standalone trust as far as was possible. After its initial financial difficulties in the financial year 2009/10, it has become a lean, well-managed trust with little excess cost. This has been recognised by successive teams of external advisers. However, should the merger not proceed, the trust will fall into deficit and end in some form of administration or managed transfer of services to other providers.

# Managing risk

Poole Hospital has a well-developed risk management and safety structure with a designated executive director lead, the director of nursing and patient services. 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.

The hospital's risk management team includes leads for health and safety, and 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 either the audit and governance committee or, if they are clinical risks, 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 trust maintained the highest level of accreditation with the National Health Service Litigation Authority (NHSLA Level 3) for its approach to risk management during 2012/13.

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
- 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.

"The trust maintained the highest level of accreditation with the NHSLA for its approach to risk management"

## Emergency preparedness

The trust's major incident plan provides a comprehensive set of procedures for dealing with sudden major incidents which present a serious threat to the health of the community, disruption to services, or could cause a large number of casualties which would require special arrangements to be implemented by hospitals, ambulance services or primary care organisations.

In common with all hospitals, we regularly test our plans for responding to major incidents and business continuity 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 exercises to test emergency plans during the year, including Exercise Zeus, Exercise Sparky and Exercise Forecourt. We have also carried out several regular communication cascades in and out of hours.

Over the course of the year emergency plans (including those for chemical, biological, radiological and nuclear incidents, major incident, flu and business continuity) have been reviewed and updated. New plans include a trust fuel plan for potential shortages.

The hospital continues to play an active role in the local resilience forum, working alongside other key organisations including the police, fire service, ambulance service and councils to ensure robust plans are in place for dealing with major incidents.

Considerable focus was placed on planning for the 2012 Olympic Games, ensuring robust plans were in place to deal with any anticipated incidents and scenarios, and subsequently managing a response during the Games.

The Trust's emergency preparedness group met regularly through the year to review activities and plan for the future.


# ANNUAL REPORT & ACCOUNTS 2012/13

# Supporting staff

## Our staff and volunteers go above and beyond for our patients - we're committed to supporting them in return

Poole Hospital is committed to engaging and involving staff. The trust has a unique philosophy, the Poole Approach, which underpins our values both as a provider of care and an employer, and pledges that we will strive to always 'listen to our staff, patients and the public' and 'give information that is relevant and accessible'. These values are supported by a wide-ranging set of communication tools that allow effective engagement and ongoing dialogue with staff.

Recognising that effective engagement and communication plays a key role during periods of transition, the trust enhanced its internal communication mechanisms during 2012/13 and developed a range of specific tools to support staff as work progressed on the proposed merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH).

The two trusts worked with The Kings Fund to support organisational development and review what is important to the workforce in terms of values and culture. A variety of events were held throughout the year including medical engagement events, a major listening event called 'The Big Conversation' and appreciative enquiry exercises, allowing staff across all professions to help shape the future organisation.

The trust has also been working closely with RBCH to ensure consistency and clarity of information on the merger. Communications took place through a variety of mechanisms including ward

packs with returnable question slips, special briefing sessions, newsletters, FAQ sheets and a shared intranet site, and information on the merger was also shared through the trust's existing communications channels.

These existing channels provide a variety of opportunities for engagement with staff across the hospital and include:

- Staff partnership forum (SPF) which promotes proactive working with staff representatives and union colleagues on a wide range of issues – the trust worked closely with the SPF during 2012/13 to ensure their involvement on key issues
- Monthly Team Brief sessions with the chief executive, attended by senior managers and heads of department, and incorporating a Q&A. Information from these sessions is cascaded to staff by managers, with an opportunity to submit feedback via the Team Brief Toolkit
- Quarterly open briefing sessions for all staff with the chief executive, offering an opportunity to ask questions in advance or at the event
- Regular team meetings, held by all directorates, care groups and professional groupings
- Weekly staff bulletin, sent to all email users each week and circulated in printed form. The bulletin welcomes submitted content from staff
- Grapevine, the trust quarterly staff magazine, which focuses on the staff behind the trust's success stories and welcomes contributions
- The staff 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 NHS staff survey

## Improving staff engagement

To further support staff through a time of change, the trust's communications service also developed and implemented a trust-wide internal communications action plan during 2012/13. A survey was carried out during August/September, in which over 200 staff took part. Participants were asked to share their opinions on existing communication tools and to give suggestions for improvements. Key actions were then implemented, including:

- Improvements to the frequency and format of briefing sessions
- Improved communications at 'ward' level, including better use of staff noticeboards and circulation of paper copies of key communications
- Development of a training module for managers on effective communication, to be implemented in 2013/14
- Improved mechanisms to support the flow of information across the organisation, including an information toolkit and new feedback forms

A report on staff communication and engagement is provided on a bi-monthly basis to the workforce committee, a sub-committee of the board of directors, by the trust's head of communications.

Staff engagement played a key role in our response to the 2011 NHS staff survey results. The results of the survey and the action plan that followed were shared with staff using many of the communication tools listed above, including staff bulletin articles, discussion at staff briefing sessions and involvement from the staff partnership forum.

Effective engagement remains a priority in our response to the 2012 national NHS staff survey results and is recognised as key to the achievement of targets within the action plan arising from this survey. A variety of communications have been taken forward in response to the staff survey in order to reach all workforce groups, and the success achieved will be duplicated in the 2013-14 reporting year.

# NHS staff survey - summary of performance

Details of the key findings from the 2012 NHS staff survey are outlined in the tables below. These include comparisons between the trust's results for the previous year, and the national average. The top and bottom five ranking scores are included along with key areas where we have seen real improvement. The lowest scoring areas form part of the trust's programme of action to achieve and sustain improvements in these areas.

## Staff survey 2012 - response rate

| | 2011 | | 2012 | | Trust improvement or deterioration |
|---|---|---|---|---|---|
| | Trust | National Average | Trust | National Average | |
| **Response rate (compared to national average for acute trusts)** | 60% | 52.5% | 51% | 51% | Decrease by 9% |

## Staff survey 2012 - top five ranking scores

| Top five ranking scores in 2012 survey (Key Finding in brackets) | 2011 | | 2012 | | Trust improvement or deterioration |
|---|---|---|---|---|---|
| | Trust | National average | Trust | National average | |
| **Staff being able to contribute towards improvements at work (Key Finding 22)** | 56% | 61% | **72%** | **68%** | Increase by 16% |
| **Staff experiencing discrimination at work over the past 12 months (Key Finding 28)** | 12% | 13% | **8%** | **11%** | Decrease by 4% |
| **Staff believing the trust provides equal opportunities for career progressing or promotion (Key Finding 27)** | 91% | 90% | **91%** | **88%** | No increase or decrease |
| **Staff receiving job-relevant training, learning or development in the last 12 months (Key Finding 6)** | 89% | 78% | **82%** | **81%** | Decrease by 7% |
| **Effective team working (Key FInding 4)** | 3.65 | 3.72 | **2.72** | **3.72** | Increase by 0.12 points |

## Staff survey 2012 - bottom five ranking scores

| Top five ranking scores in 2012 survey (Key Finding in brackets) | 2011 | | 2012 | | Trust improvement or deterioration |
|---|---|---|---|---|---|
| | Trust | National average | Trust | National average | |
| **Work pressure felt by staff (Key FInding 3)** | 3.30 | 3.12 | **3.24** | **3.08** | Decrease by 0.6 points |
| **Staff witnessing potentially harmful errors, near misses or incidents in the last month (Key FInding 13)** | 36% | 34% | **39%** | **34%** | Increase by 3% |
| **Staff appraised in the last 12 months (Key Finding 7)** | 73% | 81% | **73%** | **84%** | No increase or decrease |
| **Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (Key Finding 18)** | 17% | 15% | **33%** | **30%** | Increase of 16% |
| **Staff feeling pressure to attend for work when feeling unwell (Key Finding 20)** | 27% | 26% | **33%** | **29%** | Increase of 6% |

## Future priorities and targets

Key overall priority areas and targets for improvement have been identified in response to the 2012 staff survey results in the form of a trust-wide high-level action plan. This action plan highlights area for further improvement based on the findings listed above, and was developed with input from the staff side.

This work is set at board of director level through the workforce committee.

In addition to the trust-wide action plan, specific targets and related actions and priorities are also set at directorate and divisional level as part of a proactive response, involving divisional and corporate directors and their teams.

## Measuring progress

By agreeing 'high level' priority areas as well as directorate and divisional actions, appropriate targets can be set and actions taken which take account of differences in staff views across different parts of the organisation.

Actions arising from the staff survey are embedded as part of the weekly divisional reviews and quarterly performance reviews carried out by the executive team, and managers work with their teams, with support from HR, to address areas of commitment and those outlined in the action plan.

Information will be collected during the coming year to enable the trust to demonstrate to staff that their views have been heard – and acted on. This work will support the measurement of actions, which is co-ordinated by 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, a sub-committee of the board of directors.

## Health and wellbeing of staff

The trust has an active multidisciplinary Wellbeing at Work Group, led by the directorate of human resources. This group identifies and actively responds to staff health and wellbeing issues across the organisation. These include workplace stress with associated activity of a series of practical resilience workshops to support staff. A key element of the group's work is to ensure full implementation of the related NICE public health guidance.

## Highlight of the year: Feelgood Friday

In March 2013 the trust held its first ever dedicated wellbeing at work day for staff – Feelgood Friday.

The event provided a chance for staff to find out more about leading a healthy lifestyle, at home and at work, with advice on topics including sun awareness, healthy hearts, diet and exercise, smoking cessation and men's and women's health issues. Staff could get checked out at a mini-body MOT, in which cholesterol, weight and blood pressure were checked, or enjoy a spot of pampering with complementary massages in the tranquillity zone.

The hospital's catering team also gave away free samples of healthy soups and recipe cards so staff could make them at home.

"Our independent employee assistance provider offers a range of free, easily accessible support to staff"

## Occupational health & employee assistance

A major review of the trust's occupational health provision was undertaken during the year and as a result, the decision was taken to enter into a joint venture with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) for the provision of this service, led by RBCH.

This arrangement has been in place since 1 December 2012. As a result, occupational health staffing levels at Poole have been increased both for clinical and support staff, allowing for extended hours of service in the department.

The service is staffed by a team of registered nurses and administrative staff. Medical support is provided by an occupational health physician and two local general practitioners.

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

Additional support to staff is provided through the trust's appointed independent employee assistance provider (EAP). This service provides access to a range of free, easily accessible expert support including a confidential counselling service and debt management advice.

Since 1 November 2012 this service has been reviewed thoroughly and as part of a collaborative project with other NHS providers in the county, a new provider was appointed. This provider, Care First, has an expanded range of provision for staff, and early feedback on the available services has been very positive.

As well as providing an enhanced package of support, the new service is also provided at a competitive rate which has been achieved through the benefits of joint procurement.

# Equality and diversity

Poole Hospital is committed to equality and diversity, both as a healthcare organisation and as an employer. We work on a variety of fronts to implement the provisions of the Equality Act 2010 across services and for our staff, by ensuring our general public duties under the Equality Act are met and form part of our good practice. We do this through implementation of the NHS Equality Delivery System.

Equality, diversity, and human rights are also promoted through the work of the equality and diversity group and through the Poole Approach and the Golden Rules, which set out our values and philosophy of care and are widely known and embedded across the trust.

In line with the NHS Constitution, Poole Hospital is committed to providing equal access to 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. The trust opposes all forms of unlawful and unfair discrimination, and is also firmly committed to equality of employment (see 'A fair employer' section opposite.)

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.

The trust is a member of the Stonewall Diversity Champion programme, which we joined in 2012. Stonewall is the UK's good practice employers' forum on sexual orientation and the trust features in both the Stonewall NHS Good Practice Guide and the Healthcare Equality Index.

## 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 disabilities 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.

The Trust won an Open Doors Award in March 2013 from the Livability Charity. The award is based on the recommendations of disabled people, and recognises that we go above and beyond to welcome and cater for disabled people through the provision of excellent service.

## Staff sickness

In 2012/13 the trust's target for sickness absence was retained at 3.5%, the same as in the two previous years. At year end, this target was narrowly missed at 3.57%. Nevertheless, this is the lowest rate recorded by the trust in over a decade and compares very favourably when benchmarked with other trusts.

The trust introduced a range of positive work programmes in 2012/13, supported by HR and line managers. These included comprehensive reviews of the trust's Bradford sickness reports and occupational health assessments, reviews of incidents of sickness, preventative measures and supporting return-to-work interviews, case conferences with occupational health teams and jointly planned reviews.

The table below shows the rates experienced month by month during 2012/13.

## Mandatory employment checks

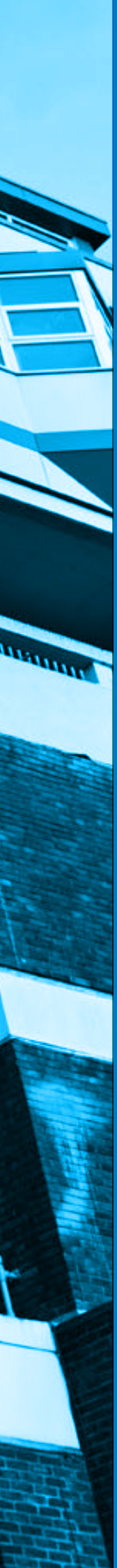
The trust's human resources service has rigorous processes and systems in place to support assurance records that mandatory pre-employment checks for new joiners (including staff, temporary workers and volunteers) are in place.

A comprehensive 'housekeeping' best practice exercise commenced in 2012, rolled out across the entire workforce, supporting new legislation and improved reporting functionality. These checks are fully embedded in the practices of the human resources department and independent reviews by governing bodies and audits undertaken within the 2012/13 reporting year have resulted in favourable assurance confirmation that good records, systems and processes are in place on behalf of the trust.

### Staff sickness rates

| April 12 | May 12 | June 12 | July 12 | Aug 12 | Sept 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 | **Year end** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.18% | 3.49% | 3.05% | 3.49% | 3.52% | 3.64% | 3.43% | 3.44% | 3.67% | 4.13% | 4.07% | 3.71% | **3.57%** |


Poole Hospital
NHS
NHS Foundation Trust





# Sustainability

## An outline of the steps we are taking to make our trust a greener place

The trust is committed to reducing its carbon footprint in line with the NHS carbon reduction strategy, and has a carbon management plan in place which outlines the hospital's strategy for managing this reduction programme, and delivering ongoing financial and environmental benefits from reduced spending in utilities and waste.

The national target reduction for the NHS has been set by central government at 10% by 2015, against a 2007/08 baseline. However, the trust has set an initial target reduction of 18% by 2015, underlining our commitment to carbon reduction and reflecting the key role public sector organisations must play in setting standards for reducing environmental damage.

The trust is registered with the Good Corporate Citizenship scheme and is due to undertake a further assessment on sustainability within the coming year.

Detailed below are key updates on areas in which the most work has taken place to date within the trust. Updates on all areas will be included in all future reporting.

### Good Corporate Citizenship model

The key areas for action are energy, water and carbon management, sustainable procurement & food, low carbon travel, transport and access, waste reduction and recycling, green spaces, staff engagement & communication, buildings and site design, organisational and workforce

development, partnership and networks, governance, IT and finance.

## Energy, water and carbon management

Working with the Carbon Trust as part of the Carbon Management Programme (CMP) in 2010 has helped the trust focus on the implementation of the CMP. This will help us achieve a carbon emission reduction in line with the national NHS target of 10% by 2015. A Carbon Reduction Opportunities Assessment has also been completed on behalf of the Carbon Trust which investigated potential opportunities to save carbon through energy efficiencies.

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

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

**Priorities and targets for 2013/14:**

- Revision of the 2010 Carbon Management Plan to reflect progress to date and ensure that carbon reductions are on mark to achieve 2015 targets
- Development of a Sustainability & Good Corporate Citizenship Action Plan
- Upgrade of CHP plant to more energy efficient model
- Initiation of an Energy Performance Contract (EnPC) energy reduction scheme with the aim of reducing utilities consumption by 25% through various infrastructure changes. The trust will work on this initiative in partnership with British Gas, and an investment grade audit has been commissioned
- The EnPC will focus on identifying energy savings through projects such as, but not limited to:
  - High efficiency lighting and controls
  - BMS expansion, upgrade and optimisation
  - Energy metering expansion and upgrade
  - Monitoring and targeting system and software
  - Air handling unit optimisation
  - Variable Volume HVAC Retrofit
  - Chilled water flow optimisation
  - Building fabric improvements
  - Energy monitoring and new system training
  - Carbon and energy awareness programmes

  It has been projected that the project will achieve between 3,300 and 5,500 tonnes of CO2 per annum. The EnPC is a long term financed project that will pay for itself and improve the patient and staff environment.
- 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.

## Sustainable procurement and food

In addition to a focus on carbon, the trust is also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. 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.

**Priorities and targets for 2013/14:**

The trust will be producing a combined Sustainable Procurement Policy with the Royal Bournemouth & Christchurch Hospitals action plan to further reduce the carbon footprint associated with procurement.

## Low carbon travel, transport and access

The trust recognises the benefits of reducing the negative environmental, health and social impacts of car travel and is committed to reducing its carbon footprint and the impact of commuting on the local community from employee-based car travel. We have a dedicated car-share scheme which enables staff to share lifts to and from work, and is designed to reduce the travel costs for staff, as well as congestion in the area.

**Priorities and targets for 2013/14:**

- Further promote the car share scheme to all staff
- Continue to promote and encourage the most sustainable form of transport to staff, patients and visitors, whenever possible.
- Update the trust's Green Travel Plan

## Waste reduction and recycling

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. 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.

A cardboard compactor has recently been purchased which allows larger volumes of cardboard to be baled and recycled. This is estimated to generate an annual income for the trust of approximately £3,000.

**Priorities and targets for 2013/14:**
Increase recycling awareness to encourage further uptake in recyclable waste segregation.

## Staff engagement and communication

The trust is committed in ensuring that staff, patients, visitors and suppliers/ contractors are able to effectively engage with, and support, the trust's carbon reduction plan. Regular awareness-raising events are also held to ensure engagement, such as a recent week-long schedule of events in support of the National Climate Week campaign.

Priorities and targets for 2013/14:

- Continued engagement with all staff, patients, visitors and suppliers/ contractors through regular articles about sustainability and energy awareness included within staff magazines and publications
- Identification and signing up of key environmental champions across the trust's departments and wards

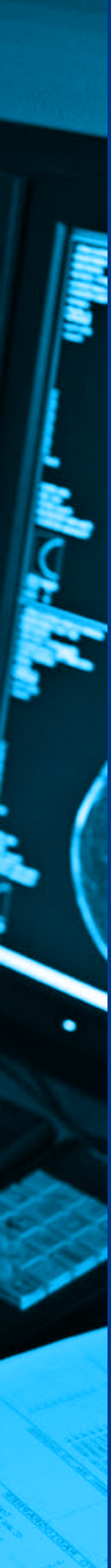
## Governance

The trust routinely reports on energy consumption through the Department of Health's 'Estates Returns Information Collection mechanism' (ERIC) and is included within the mandatory reporting under the CRC Energy Efficiency Scheme.

**Priorities and targets for 2013/14:**

- Identify a board-level lead for sustainability, this ensures that sustainability issues have visibility and ownership at the highest level of the organisation
- Establishment of sustainability working groups to ensure engagement and embedding of carbon management into all areas of work and operations
- The continual review of the impact that the CRC will have on the trust's activities both financially and operationally in terms of priorities.

# ANNUAL REPORT & ACCOUNTS 2012/13





# Non-financial information

## Important information about other areas of our work

### Handling complaints

Poole Hospital received 472 formal complaints between 1 April 2012 and 31 March 2013. At the time of preparing this report 467 had been concluded: 36% were not upheld, 31% were upheld partially, 24% were upheld in their entirety, 6% received reimbursement for the loss of property and 3% of complaints were withdrawn.

Five 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:

- Radiology was reminded of correct protocolling for particular type of CT scan.
- Manufacturer of sweat test equipment provided additional training and support to nursing staff.
- Matrons for medicine and children's services liaising to ensure that adults with autism in transition period are managed appropriately
- Review of clinic resulting in information now being forwarded to reception staff and radiotherapy nurse now checking waiting area to keep patients informed
- Leaflet written to accompany Anticoagulation Yellow book clarifying communication and referral process and consultant

ensuring that doctors have a clear understanding of process of referral
- Detailed flow chart developed to assist staff when caring for patients following a TVT procedure
- Importance of medicines reconciliation on the patient's arrival to the ward or as soon as possible thereafter reinforced to junior medical staff
- System implemented in children's unit to ensure that test results are checked and communicated to parents in a timely manner
- Review of discharge process in elderly care to ensure improvements in communication with relatives and carers
- Ward staff reminded of correct fitting of Jura walkers and the provision of advice to patients regarding their use
- Email sent by Infection Prevention and Control with regard to the disposal of soiled clothing
- Staff reminded of the uniform policy and the use of mobile phones
- Junior medical staff reminded that they must check EPR before contacting patients
- Antibiotic guidance in dermatology department reviewed and amended
- Review of threshold for lockdown on Portland Ward initiated in view of patient who absconded from the ward.
- Practice with regard to transporting soup across the dome entrance area changed
- Pathway for back pain reviewed and reinforced
- EPU information leaflet amended and sent to patient for comment.

## Counter-fraud and security

Poole Hospital embraces and complies fully with the NHS Protect standards for providers on counter fraud and security management arrangements

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 proactive 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 trust's 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 proactive exercises.

"The trust was involved in conducting over 190 clinical research studies during 2012/13"

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. As part of the NHS reforms NHS Dorset ceased to exist on 31st March 2013 and the Counter Fraud Service will be hosted by Dorset Healthcare University NHS Foundation Trust with effect from 1st April 2013.

Over the last 11 years 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 independent assessment of the trust's counter fraud arrangements is undertaken as part of the NHS Protect quality assurance programme. The trust took part in a pilot thematic assessment during the financial year 2012/13, the results of which have not yet been received.

## Research and innovation

Poole Hospital NHS Foundation Trust is committed to research, development and innovation. The trust was involved in 194 clinical research studies during 2012/13 - you can read more about these in the Quality Report on page 85. 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.

## Protecting patients' information

The trust takes its responsibility to safeguard confidential information about patients and staff very seriously. Information governance is monitored

by the trust's audit and governance committee and significant work has been undertaken to reduce the risks in this area.

In line with the trust's IT security policy:

- All trust-owned laptops are managed in accordance with the IT security policy
- Full details of each item are recorded on an inventory and encrypted to the maximum available standard
- Virus protection is closely managed
- Data must always be on a secure network area
- Written confirmation of compliance is received from the custodians
- Privately owned devices are not permitted on the main trust network
- Trust iPads are managed by the Royal Bournemouth and Christchurch Hospitals NHSFT IT department
- Non-compliance is managed by the IT security manager.

The trust has also carried out significant to reduce the risk to confidential information when handling paper records away from the hospital.

**The decor on Lulworth Ward uses colour to aid orientation**

The Information Toolkit is a nationally developed checklist of the controls and processes required for good information governance, and is one of the ways that we assess the quality and strength of our own processes. The requirements have become more stringent over the last few years and there are now 45 standards for acute hospitals.

During 2012/13 the newly appointed informatics director for the trust carried out a more rigorous review of our compliance with these 45 standards. This confirmed that we are compliant with 33 of the 45 requirements but further work is required in the other 12 areas. An action plan has been agreed by the board of directors to ensure we achieve compliance with all 45 standards during 2013/14.

## Estates round-up

During the past year the trust has invested almost £5m and made commitments for further significant expenditure in 2013/14 to ensure that patient safety and services are protected and developed.

### Refurbishment of maternity and neonatal intensive care services - £4m

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 and neonatal intensive care unit, including the special care baby unit, and finally extended in 1984 with the addition of a post-natal ward and antenatal clinic. The trust invested £700,000 in 2011/12 in the upgrade of its two maternity theatres in the central delivery suite.

For many years the trust has sought to relocate maternity services to a new building more suited to the requirements of modern services. The proposed merger with the Royal Bournemouth and Christchurch Hospitals will allow this to

be achieved within the next five years.

However, further investment is required immediately to ensure the sustainable delivery of high quality and safe services until a new building can be achieved.

The board have therefore agreed to invest £4m to address the key environmental risk issues that the service currently faces and to provide sufficient capacity to address anticipated growth over the next few years. This expenditure started in 2012/13 and will be completed by March 2014.

### Installation of 3T MRI scanner - £1m

In December, the hospital's new 3Tesla (3T) magnetic resonance imaging scanner was officially opened following a total investment of more than £2.5m. This state-of-the-art development has been made possible by a single major charitable donation in 2008 and generous support from the Poole Hospital Cancer Treatment Trust and Scanner Appeal. These charitable donations paid for the equipment in full, leaving the trust to pay only for the cost of installation, which was just over £1m including £0.6m in 2012/13.

MRI activity is forecast to rise steadily in the future due to technology and software advances. This scanner, which is only the second of its kind in the region, will provide capacity for an additional 4,000 scans per annum, which is an increase in capacity of 40%.

### Private inpatient unit - £0.5m

In September the trust opened the Cornelia Suite, its new inpatient unit for private patients. The suite is projected to deliver additional revenues in excess of £1.1m per annum, with a cumulative operating surplus of over £1.6m by Year 4 and a net surplus of over £1m by the end of Year 4, after repaying the anticipated capital costs of £0.5m.

Poole Hospital's core function will always be the provision of excellent patient centred emergency and planned care to local NHS patients, free at the point of delivery. All surplus from private patient services is reinvested in services to NHS patients. Income from private patients in 2012/13 will represent around 1% of total income, and is unlikely to ever increase above 2%, even if we are very successful in developing these services.

### Radiotherapy bunker and new linear accelerator - £5.4m

The trust embarked on the building of a new radiotherapy bunker during 2012/13, ready for the installation of a new linear accelerator in 2014/15. The trust has spent £300k in 2012/13 on planning and design and expects to complete the bunker at a total cost of £3.7m in the next 18 months. The linear accelerator itself will cost a further £1.7m and will be commissioned in 2014/15

### Refurbishment of wards – £1m

The trust has invested over £1m in its rolling programme of ward refurbishment. In the last year there have been significant improvements in a number of areas including an elderly care ward refurbished for patients with dementia, Ansty, wards C3 and E3 and in outpatients.

In spring 2012, Lulworth Ward reopened following a major refurbishment project. The project was supported by The

King's Fund's 'Enhancing The Healing Environment' programme and the trust, and was carried out to improve the ward environment for patients with dementia. A new design was developed which used colour, lighting, improved signage and artwork to support patients' independence and aid orientation.

### Estates maintenance and Infrastructure - £1.5m

The Trust has invested £1.5m in a range of engineering projects to improve the resilience of the hospital. The maintenance and improvement of our estate has included investment in water distribution systems to safeguard against legionella and other infections, electrical systems, energy management, lifts and lighting installations.

## Improving IT systems

The trust has implemented a range of new IT systems and enhancements over the year to support staff and patients, including:

- ICIP – Critical Care Patient Management System
  A new computer-based system to continually monitor patients and provide a central record for patient treatment.
- MOSAIQ – Oncology Patient Management System
  An integrated treatment management system for cancer care patients.
- MCIS – Maternity Clinical Information System
  This system enables data to be held centrally and consistently to assist clinicians in providing the best possible pre- and post-natal care.
- Order Communications for GP Surgeries
  The IT department has provided the infrastructure and ongoing support for this new system which has enabled GP surgeries to request pathology tests with more accuracy and consistency.
- Capture Stroke
  Capture Stroke is a registered stroke database which is used to collect the necessary data to support national targets and reporting requirements.

## Public consultation

From 1 February to 25 April 2012, a joint public consultation was carried out with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust on the proposed merger of the two organisations.

The consultation 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.

### 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.

## Consultation outcome

The feedback provided in the consultation was reviewed and considered by the governors and directors of both trusts and resulted in the following:

The name 'Bournemouth and Poole NHS Foundation Trust' has been chosen for the new organisation.

The public membership constituencies for the new organisation are:

- Bournemouth
- Poole
- Dorset (including local authority areas for Christchurch, East Dorset, North Dorset, Purbeck, West Dorset and Weymouth and Portland)
- Hampshire and Wiltshire

The following classes make up the staff constituency of the new organisation:

- Medical staff
- Clinical staff
- All other staff

The council of governors will be made up of 31 governors – 20 public governors, six each from the Bournemouth, Poole and Dorset constituencies and two from the Hampshire and Wiltshire constituency. There will also be five staff governors and six appointed governors representing local stakeholder organisations.

The minimum age to be a member of the new organisation will be 12 and the minimum age to vote and to be a governor will be 16.

The consultation proposals for the new organisation on the size and composition of the board of directors, the constitution and elections were adopted without change.

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# Governance & membership

## Information on our governance arrangements and the key role members play in shaping our future

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 licence.

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: www.poole.nhs.uk/about_us/foundation_trust_governance_arrangements/documents/D23-ChairmanvChiefExecutiveResposibilitiesStatement_000.pdf

**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.

**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.

**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.

**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.

## Board evaluation

The performance of the board, its committees and individual directors is subject to annual evaluation and regular external review. The process for the evaluation of the chairman and non-executive directors is approved and the outcome received, by the CoG.

In 2012/13 the chairman, non-executive directors and executive directors were subject to annual evaluation.

In 2011/12 external assessors presented to the board of directors a rigorous evaluation of the performance of the board and its committees. This assessment was presented to Monitor as part of the recovery programme from significant breach of our terms of authorisation. In early 2012 Monitor determined that the Trust was no longer in significant breach of its terms of authorisation.

In 2012/13, as part of the process for the proposed merger with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, the board and its committees have come under further internal and external scrutiny.

During 2012/13, PwC undertook a review of the trust's position with regards to Monitor's Quality Governance Framework.

Recognising the intense scrutiny of the board and its committees in early 2012, and the further scrutiny associated with the merger programme, a formal annual evaluation of the board and its committees has been deferred pending the outcome of the strategic position in relation to the merger.

## Board development

The board has continued its ongoing development through board seminars. Topics included the strategic direction for the trust, internal transformation, revalidation, cost improvement programme, south west pay consortium, performance targets, clinical services strategy and merger.

The board also attended a joint workshop with the governors in January 2013 which focused on merger discussions, IT strategy

and the palliative care strategy.

In October 2012, the board reviewed the Monitor publication 'Director-governor interaction – a best practice guide'. This is to be reviewed by the council of governors at their April 2013 meeting.

## Key activities of the board

Considerable focus was placed on the proposed merger with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust during the year. The board held discussions on key issues to support progress in the development of the case for merger and received updates on a monthly basis from the chief executive and merger programme lead.

In spite of the significant merger work programme, the board continued to focus on service quality as its key priority during the year, along with effective financial management.

The work of the south west pay, terms and conditions consortium (chaired by the chief executive of Poole Hospital) was discussed by the board and the consortium's final report – which contained nine recommendations concerning the role pay, terms and conditions could play in meeting the financial challenges faced by NHS trusts – was considered at the March board meeting. The board accepted eight out of the nine recommendations contained in the report.

## 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. It can be found on our website at: 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.

# 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 Council of Governors 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.

**Other directorships and registered interests***
Trustee, Brendon Care
Stepson works for non-audit services at Deloittes (external auditors)

**Other committee memberships**
Appointments committee
Council of governors
Finance and investment committee
Nominations, remuneration and evaluation committee
Remuneration committee

## Dame Yvonne Moores, non- executive director; vice-chairman, chairman of the quality, safety and performance committee

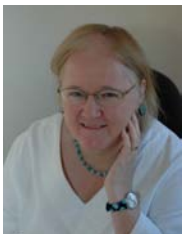
Date of appointment: 1 November 2006
Date of expiry: 31 October 2013

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 also 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.

**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 of the 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.

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

**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, which he visits twice a year.

**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 of the 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.

**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 of the 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.

**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 NHS Hampshire and Isle of Wight

**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.

**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

## 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.

**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
Date of expiry: 14 September 2012

Gareth has nearly two decades of experience in the NHS, working in strategic roles in acute hospitals in Suffolk and Birmingham, as well as PCT and commissioning services.

## 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***
Wife is a nurse at The Royal Bournemouth & Christchurch Hospitals NHSFT

**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

In addition, Sarah-Jane Taylor, director of human resources and organisational development and Peter Gill, director of informatics serves, are on the board in a non-voting capacity.

*Interests recorded as at 31 March 2013.

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, apart from Dame Yvonne Moores and Jean Lang who were appointed by the Appointments Commission as they were already in post when the hospital became a foundation trust.

The chairman has no other significant commitments.

## Attendance at board of directors meetings 2012/13

| NAME OF COMMITTEE: | BOARD OF DIRECTORS | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Membership (as per Terms of Reference) | Meeting Dates | | | | | | | | | | | |
| | April 2012 | May 2012[1] | May 2012 | June 2012 | July 2012 | September 2012* | September 2012 | October 2012 | November 2012 | January 2013 | February 2013 | March 2013 |
| Angela Schofield<br>Chairman | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Chris Bown<br>Chief executive | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Gareth Corser [2]<br>Director of strategy | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | |
| Jean Lang<br>Non-executive director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ |
| Ian Marshall<br>Non-executive director | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ |
| Michael Mitchell<br>Non-executive director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Yvonne Moores<br>Non-executive director/ vice chairman | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mary Sherry<br>Chief operating officer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Martin Smits<br>Director of nursing and patient services | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Guy Spencer<br>Non-executive director/ senior independent director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Robert Talbot<br>Medical director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Paul Turner<br>Director of finance | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Nick Ziebland<br>Non-executive director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✓ | ✓ | ✓ |
| Was the meeting quorate? Y/N | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |

1 Extra Part 2 meeting
2 Gareth Corser resigned September 2012
* Special meeting

# Audit and governance committee

**Chairman: 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 October 2012, the council of governors (CoG) approved the appointment of Deloittes to succeed Pricewaterhouse Coopers LLP as external auditors for a three year period. 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 2012/13

| NAME OF COMMITTEE: | AUDIT & GOVERNANCE COMMITTEE | | | | |
|---|---|---|---|---|---|
| REPORTS TO: | BOARD OF DIRECTORS | | | | |
| | Meeting Dates | | | | |
| **Membership (as per Terms of Reference)** | May 2012 | September 2012 | November 2012 | January 2013 | March 2013 |
| Jean Lang<br>Chairman | ✓ | ✓ | ✓ | ✓ | ✓ |
| Ian Marshall<br>Non-executive director | ✓ | ✓ | ✗ | ✗ | ✗ |
| Yvonne Moores<br>Non-executive director | ✓ | ✓ | ✓ | ✗ | ✗ |
| Guy Spencer<br>Non-executive director | ✓ | ✓ | ✓ | ✓ | ✓ |
| **In attendance:** | | | | | |
| Angela Schofield<br>Trust chairman | ✗ | ✗ | ✓ | ✗ | ✗ |
| Executive Directors/ Deputies | 4 | 3 | 2 | 3 | 2 |
| External Audit* | 2 | 2 | 1 | 2 | 1 |
| Internal Audit | 2 | 1 | 2 | 1 | 2 |
| Counter Fraud | 0 | 1 | 1 | 1 | 1 |
| Was the meeting quorate? Y/N | Y | Y | Y | Y | Y |

*External Auditors changed October 2012

# Finance and investment committee

**Chairman: Michael Mitchell, non-executive director**

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 prior to the board meeting or more frequently if required.

## Attendance at finance and investment committee 2012/13

| NAME OF COMMITTEE: | FINANCE & INVESTMENT COMMITTEE | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| REPORTS TO: | BOARD OF DIRECTORS | | | | | | | | | | | |
| | Meeting Dates | | | | | | | | | | | |
| **Membership (as per Terms of Reference)** | April 2012 | May 2012 | June 2012 | July 2012 | August 2012 | September 2012 | October 2012 | November 2012 | December 2012 | January 2013 | February 2013 | March 2013 |
| Michael Mitchell<br>Chairman | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Chris Bown<br>Chief executive | ✓ | ✓ | ✓ | ✗ | ✗ | ✗ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ |
| Ian Marshall<br>Non-executive director | ✓ | ✓ | ✗ | ✓ | ✓* | ✗ | ✓ | ✓ | ✓* | ✓ | ✗ | ✓ |
| Angela Schofield<br>Trust chairman | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ |
| Mary Sherry<br>Chief operating officer | ✗ | ✗ | ✗ | ✓ | ✗ | ✓ | ✗ | ✗ | ✓ | ✗ | ✓ | ✗ |
| Paul Turner<br>Director of finance | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **In attendance:** | | | | | | | | | | | | |
| Andrew Goodwin<br>Deputy director of finance | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Jean Lang<br>Non-executive director | | | | | | | | | | | ✓ | |
| Was the meeting quorate? Y/N | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |

* Via telephone

# Quality, safety and performance committee

**Chairman: Dame Yvonne Moores, non-executive director**

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.

## Attendance at quality, safety and performance committee 2012/13

| NAME OF COMMITTEE: | QUALITY, SAFETY & PERFORMANCE COMMITTEE | | | | | |
|---|---|---|---|---|---|---|
| REPORTS TO: | BOARD OF DIRECTORS | | | | | |
| | Meeting Dates | | | | | |
| **Membership (as per Terms of Reference)** | May 2012 | July 2012 | September 2012 | November 2012 | January 2013 | March 2013 |
| Yvonne Moores<br>Chairman | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Mary Sherry<br>Chief operating officer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Martin Smits<br>Director of nursing and patient services | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ |
| Robert Talbot<br>Medical director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Nick Ziebland<br>Non-executive director | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Was the meeting quorate? Y/N | Y | Y | Y | Y | Y | Y |

# Workforce committee

**Chairman: Guy Spencer, non-executive director**

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.

## Attendance at workforce committee 2012/13

| NAME OF COMMITTEE: | WORKFORCE COMMITTEE | | | | | |
|---|---|---|---|---|---|---|
| REPORTS TO: | BOARD OF DIRECTORS | | | | | |
| | Meeting Dates | | | | | |
| **Membership (as per Terms of Reference)** | April 2012 | June 2012 | August 2012 Deferred to September | October 2012 | December 2012 | February 2013 |
| Guy Spencer<br>Chairman | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Jean Lang<br>Non-executive director | ✓ | ✗ | ✗ | ✓ | ✓ | ✓ |
| Mary Sherry<br>Chief operating officer | ✓ | ✗ | ✗ | ✓ | ✓* | ✓ |
| Martin Smits<br>Director of nursing and patient services | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Robert Talbot<br>Medical director | ✓ | ✗ | ✓ | ✓ | ✗ | ✓ |
| Sarah Jane Taylor<br>Director of HR | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Nick Ziebland<br>Non-executive director | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ |
| Was the meeting quorate? Y/N | Y | Y | Y | Y | Y | Y |

*attended for one item on the agenda

# Appointments committee

**Chairman: Angela Schofield, trust chairman**

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 27 March 2013 to approve the appointment made on 19 November 2012 of the director of informatics and to agree the reappointment of the medical director from 1 April 2013.

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

## Attendance at appointments committee 2012/13

| NAME OF COMMITTEE: | APPOINTMENTS COMMITTEE |
|---|---|
| REPORTS TO: | BOARD OF DIRECTORS |
| **Membership (as per Terms of Reference)** | Meeting Dates |
| | 26 March 2013 |
| Angela Schofield<br>Chairman | ✓ |
| Dame Yvonne Moores<br>Non-Executive Director | ✓ |
| Jean Lang<br>Non-Executive Director | ✓ |
| Ian Marshall<br>Non-Executive Director | ✓ |
| Michael Mitchell<br>Non-Executive Director | ✓ |
| Guy Spencer<br>Non-Executive Director | ✓ |
| Nick Ziebland<br>Non-Executive Director | ✓ |
| **In attendance:** | |
| Chris Bown<br>Chief Executive | ✓ |
| Sarah-Jane Taylor<br>Director Of Hr & Organisational Development | ✓ |

# Remuneration committee

**Chairman: Angela Schofield, trust chairman**

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 performance and/or salary is discussed. The chief executive attends only to advise on issues concerning the performance of directors.

The committee met in May 2012 and July 2012, 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.

## Attendance at remuneration committee 2012/13

| NAME OF COMMITTEE: | REMUNERATION COMMITTEE | |
|---|---|---|
| REPORTS TO: | BOARD OF DIRECTORS | |
| **Membership (as per Terms of Reference)** | Meeting Dates | |
| | 28 May 2012 | 24 July 2012 |
| Angela Schofield<br>Chairman | ✓ | ✓ |
| Dame Yvonne Moores<br>Non-Executive Director | ✓ | ✓ |
| Jean Lang<br>Non-Executive Director | ✓ | ✓ |
| Ian Marshall<br>Non-Executive Director | ✓ | ✓ |
| Michael Mitchell<br>Non-Executive Director | ✓ | ✓ |
| Guy Spencer<br>Non-Executive Director | ✓ | ✓ |
| Nick Ziebland<br>Non-Executive Director | ✓ | ✓ |
| **In attendance:** | | |
| Sarah-Jane Taylor<br>Director Of Hr & Organisational Development | ✓ | ✓ |
| Chris Bown<br>Chief Executive | ✓ | ✓ |

## Remuneration report

| NAME & TITLE | 2012/13 | | | 2011/12 | | |
|---|---|---|---|---|---|---|
| | Salary | Other Remuneration | Benefits in Kind | Salary | Other Remuneration | Benefits in Kind |
| | (bands of £5000) £000 | (bands of £5000) £000 | (bands of £100) £100 Note 1 | (bands of £5000) £000 | (bands of £5000) £000 | (bands of £100) £100 Note 1 |
| **Mr. Christopher Bown** Chief Executive | 145-150 | - | - | 145-150 | - | - |
| **Mr. Gareth Corser** Director of Strategy and Business Development (Note 2) | 45-50 | - | - | 65-70 | - | - |
| **Mr. Peter Gill** Director of Informatics (Note 3) | 15-20 | - | - | - | - | - |
| **Mrs. Jean Lang** Non-Executive Director | 10-15 | - | - | 10-15 | - | - |
| **Mr. Ian Marshall** Non Executive Director | 10-15 | - | - | 10-15 | - | - |
| **Mr. Michael Mitchell** Non Executive Director | 10-15 | - | - | 15-20 | - | - |
| **Dame Yvonne Moores** Non Executive Director | 10-15 | - | - | 15-20 | - | - |
| **Mrs. Angela Schofield** Chairman | 35-40 | - | - | 35-40 | - | - |
| **Mrs. Mary Sherry** Chief Operating Officer | 105-110 | - | - | 110-115 | - | - |
| **Mr. Martin Smits** Director of Nursing | 95-100 | - | - | 90-95 | - | - |
| **Mr. Guy Spencer** Non Executive Director | 10-15 | - | - | 10-15 | - | - |
| **Mr. Robert Talbot** Medical Director (Note 4) | 85-90 | 85-90 | - | 85-90 | 85-90 | - |
| **Mrs. Sarah-Jane Taylor** Director of HR and Organisational Development | 90-95 | - | - | 65-70 | - | - |
| **Mr. Paul Turner** Director of Finance | 120-125 | - | - | 125-130 | - | - |
| **Mr. Nick Ziebland** Non Executive Director | 10-15 | - | - | 5-10 | - | - |

Note 1. Benefits in kind relate to the profit element on business mileage claimed.
Note 2. Mr. Gareth Corser resigned as Director of Strategy and Business Development on 14 September 2012
Note 3. Mr. Peter Gill was appointed Director of Informatics on 19 November 2012 as a joint appointment with Royal Bournemouth and Christchurch Hospital NHS Foundation Trust (RBCH). 50% of Mr. Gill's costs have therefore been included in the pay bandings above.
Note 4. Other remuneration relates to clinical work undertaken during the year.

# Pension benefits

| NAME & TITLE | Real increase in pension sum at age 60 | Real increase in pension lump sum at age 60 | Total accrued pension and related lump sum at age 60 at 31 March 2013 | Cash Equivalent Transfer Value at 31 March 2013 | Cash Equivalent Transfer Value at 1 April 2012 | Real Increase in Cash Equivalent Transfer Value |
|---|---|---|---|---|---|---|
| | (bands of £2500) £000 | (bands of £2500) £000 | (bands of £5000) £000 | £000 | £000 | £000 |
| Mr. Christopher Bown<br>Chief Executive | (0-2.5) | (2.5-5) | 225-230 | 1,082 | 1,015 | 14 |
| Mr. Peter Gill<br>Director of Informatics (Note 1) | 0-2.5 | 2.5-5 | 35-40 | 150 | 125 | 18 |
| Mr. Martin Smits<br>Director of Nursing | 0-2.5 | 2.5-5 | 170-175 | 931 | 832 | 55 |
| Mrs. Mary Sherry<br>Chief Operating Officer | (0-2.5) | (0-2.5) | 125-130 | 676 | 629 | 14 |
| Mr. Robert Talbot<br>Medical Director | n/a | n/a | n/a | n/a | n/a | n/a |
| Mrs. Sarah-Jane Taylor<br>Director of HR and Organisational Development (see Note 2) | n/a | n/a | 45-50 | 503 | 53 | n/a |
| Mr Paul Turner<br>Director of Finance | 0-2.5 | 0-2.5 | 135-140 | n/a | 750 | n/a |

Note 1. Mr. Peter Gill is a joint appointment with RBCH and therefore only 50% of his costs have been included above.
Note 2. Mrs. Sarah-Jane Taylor is a member of the 2008 Pension Scheme and the pension lump sum is not applicable. An accrued pension from a former employer was transferred into the NHS Pension Scheme during the year

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.

## 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 2012/13 was £170,000-£175,000. This was 7.3 times the median remuneration of the workforce which was £23,589 (whole time equivalent) - the figure for 2011/12 was 7.5.

The median pay calculation is based on:

- Payments made to staff in post on 31 March 2013
- 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 2013 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 expenditure at 31st March 2013 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. 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 (2011/12 £23,589).

The higher paid director is excluded for the median pay calculation.

The higher 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.

Signed

Chris Bown
Chief Executive

Date: 29 May 2013

# 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 licence 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 the senior independent director.

The council's lead governor is Jane LLoyd, while James Pride is deputy chairman.

**During 2012/13 the council of governors was made up as follows:**

Elected representatives for Bournemouth:

- Terence Purnell
- Brian Newman

Elected representatives for Poole:

- Emma Chamberlain (until 31 Oct 2012)
- Andrew Creamer
- Vivien Duckenfield
- Barry Faith (from 1 Nov 2012)
- Geof Hermsen (from 1 Nov 2012)
- Richard King
- James Pride
- Elizabeth Purcell
- Gerald Rigler (until 31 Oct 2012)
- Sandra Yeoman

Elected representatives for Purbeck, East Dorset & Christchurch:

- Christopher Archibold (until 31 Oct 2012)
- Geoffrey Carleton (from 1 Nov 2012)
- Rosemary Gould
- Barbara Hooper (from 1 May 2012)

Elected representative for North Dorset, West Dorset, Weymouth and Portland:

- Isabel McLellan

Elected staff representatives:

- Lynn Cherrett (clinical staff)
- Kris Knudsen (clinical staff)
- Sylvia Lowrey (clinical staff) (from 1 Nov 2012)
- Sue Power (clinical staff) (until 31 Oct 2012)
- Canon Jane LLoyd (non-clinical staff)

Nominated representatives from partner organisations:

- John Adams, Bournemouth Borough Council (from 26 Nov 2012)
- Graham Avis, NHS Dorset (until 31 March 2013)
- Judith Geddes, Bournemouth Borough Council (until 24 August 2012)
- Jenny Jenkin, Bournemouth University (until 28 January 2013)
- Cllr David Jones, Dorset County Council
- Glyn Smith, NHS Bournemouth & Poole (until 31 March 2013)
- Cllr Ann Stribley, Borough of Poole

## 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 Isabel McLellan started her new three year term of office on 1 May 2012.
- The second public seat for the Purbeck, East Dorset and Christchurch constituency closed on 20 April 2012 resulting in Barbara Hooper being elected for a three year term of office commencing on 1 May 2012.

A notice of election was published in August 2012 for six public seats and two staff seats, all to commence a three year term of office on 1 November 2012:

- The clinical staff seats were uncontested resulting in a re-election of Kris Knudsen and a new post for Sylvia Lowrey.
- The Poole constituency elected four seats resulting in the re-election of Andrew Creamer and Sandra yeoman and new posts for Barry Faith and Geof Hermsen.
- The Bournemouth constituency elected one seat resulting in the re-election of Brian Newman.
- The Purbeck, East Dorset and Christchurch constituency elected one seat resulting in a return for Geoffrey Carleton to the Council of Governors.

All elections were held in accordance with the election rules set out in the trust's constitution.

## Governor expenses

During the period of 2012/13 six governors claimed expenses for mileage and related car parking charges to attend meetings or training events both locally and nationally*:

| Name | Total |
|---|---|
| Andrew Creamer | £3.60 |
| Vivien Duckenfield | £158.30 |
| Geof Hermsen | £113.96 |
| Brian Newman | £274.35 |
| Terence Purnell | £94.45 |
| Isabel McLellan | £432.20 |

* wherever possible governors will car share when attending events in the region

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

## Council of governors meetings 2012/13 - attendance register

| NAME | CONSTITUENCY | TYPE OF MEMBERSHIP (THREE YEAR TERM) | APPOINTED DATE | RE APPOINTED DATE | APPOINTMENT EXPIRES | Meeting Dates | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 19 April 2012 | 28 June 2012 | 4 October 2012[1] | 9 January 2013 |
| John Adams | Bournemouth Borough Council | Appointed | 26.11.12 | | 25.11.15 | | | | ✓ |
| Christopher Archibold | Purbeck, East Dorset & Christchurch | Elected | 01.11.09 | | 31.10.12 | ✗ | ✓ | ✗ | |
| Graham Avis | NHS Dorset | Appointed | 01.11.10 | | 31.03.13 | ✓ | ✓ | ✓ | ✓ |
| Geoffrey Carleton | Purbeck, East Dorset & Christchurch | Elected | 01.11. 12<br>01.05.09 | | 31.10.15<br>30.04.12 | ✓ | | | ✗ |
| Emma Chamberlain | Poole | Elected | 01.11.09 | | 31.10.12 | ✓ | ✓ | ✓ | |
| Lynn Cherrett | Clinical staff | Elected | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✗ | ✓ |
| Andrew Creamer | Poole | Elected | 01.11.07 | 01.11.09 &<br>01.11.12 | 31.10.15 | ✓ | ✓ | ✓ | ✓ |
| Vivien Duckenfield[2] | Poole | Elected | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✓ | ✓ |
| Barry Faith | Poole | Elected | 01.11.12 | | 31.10.15 | | | | ✓ |
| Judith Geddes | Bournemouth Borough Council | Appointed | 07.04.11 | | 24.08.12 | ✗ | ✗ | | |
| Rosemary Gould | Purbeck, East Dorset & Christchurch | Elected | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✓ | ✓ |
| Geof Hermsen | Poole | Elected | 01.11.12 | | 31.10.15 | | | | ✓ |
| Barbara Hooper | Purbeck, East Dorset & Christchurch | Elected | 01.05.12 | | 30.04.15 | | ✓ | ✓ | ✓ |
| Jenny Jenkin | Bournemouth University | Appointed | 01.11.10 | | 28.01.13 | ✓ | ✓ | ✓ | ✓ |

1 Annual Members Meeting followed the Council of Governors Meeting
2 Lead Governor to 19.10.12
3Lead Governor from 20.10.12
4 Deputy Chairman

## Council of governors meetings 2012/13 - attendance register cont.

| NAME | CONSTITUENCY | TYPE OF MEMBERSHIP (THREE YEAR TERM) | APPOINTED DATE | RE APPOINTED DATE | APPOINTMENT EXPIRES | Meeting Dates | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 19 April 2012 | 28 June 2012[1] | 4 October 2012 | 9 January 2013 |
| David Jones | Dorset County Council | Appointed | 01.07.10 | | 30.06.13 | ✗ | ✓ | ✗ | ✗ |
| Richard King | Poole | Elected | 01.11.10 | | 31.10.13 | ✓ | ✓ | ✗ | ✓ |
| Kris Knudsen | Clinical staff | Elected | 01.11.09 | 01.11.12 | 31.10.15 | ✓ | ✓ | ✓ | ✓ |
| Jane LLoyd[3] | Non-clinical staff | Elected | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✓ | ✓ |
| Sylvia Lowrey | Clinical Staff | Elected | 01.11.12 | | 31.10.15 | | | | ✓ |
| Isabel McLellan | N Dorset, W Dorset, Weymouth & Portland | Elected | 01.05.09 | 01.05.12 | 30.04.15 | ✓ | ✗ | ✓ | ✗ |
| Brian Newman | Bournemouth | Elected | 01.11.09 | 01.11.12 | 31.10.15 | ✓ | ✓ | ✓ | ✓ |
| Sue Power | Clinical Staff | Elected | 01.11.09 | | 31.10.12 | ✓ | ✗ | ✓ | |
| James Pride[4] | Poole | Elected | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✓ | ✓ | ✓ |
| Elizabeth Purcell | Poole | Elected | 01.11.07 | 01.11.10 | 31.10.13 | ✓ | ✗ | ✗ | ✓ |
| Terence Purnell | Bournemouth | Elected | 01.11.07 | 01.11.10 | 31.10.13 | ✗ | ✓ | ✓ | ✓ |
| Gerald Rigler | Poole | Elected | 01.11.09 | | 31.10.12 | ✗ | ✓ | ✗ | |
| Glyn Smith | NHS Bournemouth & Poole | Appointed | 01.11.07 | 01.11.10 | 31.3.13 | ✓ | ✓ | ✗ | ✗ |
| Ann Stribley | Poole Borough Council | Appointed | 27.06.11 | | 26.06.14 | ✓ | ✓ | ✗ | ✗ |
| Sandra Yeoman | Poole | Elected | 01.11.09 | 01.11.12 | 31.10.15 | ✓ | ✓ | ✓ | ✓ |

| | | | | |
|---|---|---|---|---|
| No. public governors attending | 11 | 12 | 10 | 12 |
| No. appointed governors attending | 4 | 5 | 2 | 3 |
| No. staff governors attending | 4 | 3 | 3 | 4 |

## Board member attendance at the council of governors 2012/13

| | Meeting Dates | | | |
|---|---|---|---|---|
| | 19 April 2012 | 28 June 2012 | 4 October 2012 | 9 January 2013 |
| **Chris Bown**<br>Chief executive | ✓ | ✓ | ✓ | ✓ |
| **Gareth Corser**<br>Director of strategy and business development | ✓ | ✗ | | |
| **Jean Lang**<br>Non-executive director | ✗ | ✗ | ✗ | ✗ |
| **Ian Marshall**<br>Non-executive director | ✗ | ✗ | ✗ | ✗ |
| **Michael Mitchell**<br>Non-executive director | ✗ | ✗ | ✗ | ✗ |
| **Yvonne Moores**<br>Non-executive director/vice chairman | ✓ | ✗ | ✗ | ✗ |
| **Angela Schofield**<br>Chairman | ✓ | ✓ | ✓ | ✓ |
| **Mary Sherry**<br>Chief operating officer | ✗ | ✓ | ✓ | ✗ |
| **Martin Smits**<br>Director of nursing and patient services | ✓ | ✓ | ✓ | ✓ |
| **Guy Spencer**<br>Non-executive director/ senior independent | ✓ | ✓ | ✓ | ✓ |
| **Robert Talbot**<br>Medical director | ✗ | ✗ | ✗ | ✗ |
| **Paul Turner**<br>Director of finance | ✓ | ✓ | ✓ | ✓ |
| **Nick Ziebland**<br>Non-executive director | ✗ | ✗ | ✓ | ✗ |

# Nominations, remunerations & 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 2012/13 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) – until 28 Jan 2013

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

On 19 April 2012 the Committee considered:

- The governance cycle for the committee
- The collective performance of the Council of Governors
- The annual report on the work of the committee

On 28 June 2012 the Committee considered:

- The Chairman's and Non-Executive Directors' remuneration and allowances
- The outcome of the Chairman's performance review for 2011/12
- The outcome of the Non-Executive Directors' performance review for 2011/12
- The attendance of a Governor

On 8 January 2013 (electronically facilitated) the Committee considered:

- The governance cycle for the committee
- The attendance of a governor

Selected members of the committee also supported the appointment process of the proposed Chairman and Non-Executive Directors for the new merged organisation. On the recommendation of the nominations, remuneration and evaluation committee, the council of governors approved:

- The chairman's and non-executive directors' remuneration and allowances

## Nominations, remunerations and evaluation committee 2012/13 - attendance register

| Name | Constituency | Type of Membership | Meeting Dates | | |
|---|---|---|---|---|---|
| | | | 19 April 2012 | 28 June 2012 | 9 January 2013* |
| Mrs Angela Schofield | Chairman | | ✓ | ✓ | ✓ |
| Mr Guy Spencer | Non-executive director/ senior independent | | | ✓[1] | |
| Ms Jenny Jenkin | Bournemouth University | Appointed 3 years | ✓ | ✓ | ✓ |
| Ms Kris Knudsen | Clinical Staff | Elected 3 years | ✓ | ✓ | ✓ |
| Mr Jamie Pride | Poole | Elected 3 years | ✓ | ✓ | ✓ |
| Mrs Elizabeth Purcell | Poole | Elected 3 years | ✓ | ✗ | ✓ |

[1] Mr Spencer attended the meeting to lead on the annual appraisal of the Chairman.
* Meeting held electronically.

# 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 5,872 public members. The annual target was for a year end figure of 5,900 members which was narrowly missed. The trust gained 280 new members during the year, but also lost 282 members. Governors remained concerned that the additional costs of recruiting and managing a membership at the higher level would exacerbate the financial pressures faced by the trust.

The staff and volunteer members total was 4,434. 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 | 2,983 |
| Purbeck, East Dorset and Christchurch | 1,749 |
| Bournemouth | 878 |
| North Dorset, West Dorset and Weymouth and Portland | 262 |

**Staff constituency**

| | |
|---|---|
| Clinical | 3271 |
| Non-clinical (including volunteers) | 1163 |

## 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:

- Bournemouth University health and

wellbeing week
- Wimborne Townswomen Guild
- Lewis Manning conference
- Poole Women's Fellowship
- Oakdale Ladies evening

The membership engagement and recruitment reference group of the CoG had four meetings during the year; the group is chaired by a governor and is supported by the membership team. During the year the new group reviewed progress against the membership strategy. The group also provided the leadership for the trust's first members' health talk in February 2013 (see below) and provided input into the annual members' meeting topics and recruitment and engagement opportunities throughout the year.

Recruitment and engagement events during the year focused within the hospital and some local libraries.

The trust held its annual members' meeting on 4 October 2012. 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 very well attended and Dr Mike Bayne, clinical director for cancer care, provided a presentation on radiotherapy in Dorset which was very well received.

The trust held its first members' health talk in February 2013, on the topic of dementia care within the hospital. This was very well attended and received welcome support from the Alzheimer's Society. There were stands available for members to browse before and after the event.

The staff governors continue to hold staff surgeries at which staff members can express views on services and developments within the hospital. This is then anonymously fed back to the chairman and chief executive of the trust.

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.

## Highlight of the year: First members' talk

The trust held its first health talk for foundation trust members in February. Understanding Dementia featured presentations from Dr Premila Fade consultant physician and dementia clinical lead, Val Horn matron for older people's services and Kate Jones, dementia nurse specialist.

During the presentations, staff explained more about dementia and talked about the care offered at Poole Hospital, and changes that have been implemented to help dementia patients across the trust.

Karen Cosgrove from the Alzheimer's Society also took to the stage to join the panel for the Q&A session. The event was attended by more than 100 trust members and 64% of those who completed feedback forms rated the event as 'excellent', while a further 32% rated it 'good'.

# Code of governance compliance statement 2012/13

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.gov.uk/sites/default/files/Code%20of%20Governance_WEB%20(2).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.

The trust has met the provisions of the code D.2.1 however the annual evaluation of the board and its committees is deferred pending the outcome of the strategic position with regards to the proposed merger with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. However, the board has undertaken the evaluation activities outlined on page 55.

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 three 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

## An outline of how the trust has performed against key quality measures

Poole Hospital includes a quality report within the annual report for the fifth year running. The reason for doing this is to help our patients, the 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 patient 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 distractions the Trust has faced in discussing proposals for a future merger. We were particularly pleased to receive a very positive endorsement from patients reporting on their experience of the Trust during the year. Patients this year told us that we had improved on our excellent performance of the previous year.

The Board of Directors is proud of what staff have achieved in maintaining the highest standards in the fundamentals of care particularly in improving nutrition, preventing harm from falls and preventing infections. Further evidence of our commitment to patient safety was provided by the National Patient Safety Agency. 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 83% of all reported incidents resulted in no harm to patients compared with a national average of 71% (for similar Trusts).

It is a testament to all our staff and their hard work that patients rated Poole Hospital the best acute hospital in Dorset and the Trust was one of only six district general hospitals nationally to score 2 or more better performing marks in the national patient survey in 2012 published by the Care Quality Commission in April 2013.

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 as a whole Trust being rated so highly by our patients. My thanks go to all our staff.

During the forthcoming year 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 2012-2013, we made good progress against three of our key quality improvement measures. We fully achieved what we set out to achieve in last year's quality report in those three key areas, readmissions, delayed discharges and infection prevention. We did not achieve our other two improvement targets in the right patients into the right bed all of the time or in waiting times in the Accident and Emergency department principally because of the pressures on hospital admissions throughout the winter. Details of what we have achieved and of where we did not achieve what we planned can be found later on in this report.

Alongside these quality improvements there has been the improvement in measures of fundamental care in particular preventing harm from patient falls and preventing hospital acquired infections. During this last year the Trust has been particularly successful in managing patients presenting with diarrhoea and vomiting (norovirus) this was in spite of plenty of the illness in the community. Clinical staff have worked really hard to achieve this significant improvement over the position in 2011-2012. Although the Trust missed its targets for MRSA (target 1 case, outcome 4 cases) and Clostridium Difficile (target 25 cases, outcome 27 cases) the overall picture on infection prevention is positive with no cases a result of cross contamination and most cases unavoidable.

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 timeliness of treatment and discharge/transfer of patients in the Accident and Emergency Department.

The Trust maintained its registration as a healthcare provider with the Care Quality Commission. Throughout 2012-2013 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 through its Quality Risk Profile on a regular basis throughout the year for quality and safety and these assessments show a

consistent pattern of achievement against patient safety and quality outcomes.

The Care Quality Commission undertook unannounced inspections of the Trust in July 2012 and December 2012. The Trust was pleased to have the Care Quality Commission confirm fully compliance with all the standards for acute hospitals in the last inspection following work undertaken after the July inspection.

The Trust was criticised during the year for the percentage of staff outside children's services who had higher levels of safeguarding training. The Trust has taken action in this area and achieved the targets set during the year. The focus on improvement in this area will continue.

## 2. Quality improvements in 2012/13

The Trust set out 5 quality improvements for 2012-2013 in its Quality Report for 2011-2012. The Trust has worked hard to achieve these improvements with success. In summary the areas we set to improve quality improvement areas are:

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

### 2.2 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.

### 2.3 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.

### 2.4 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.

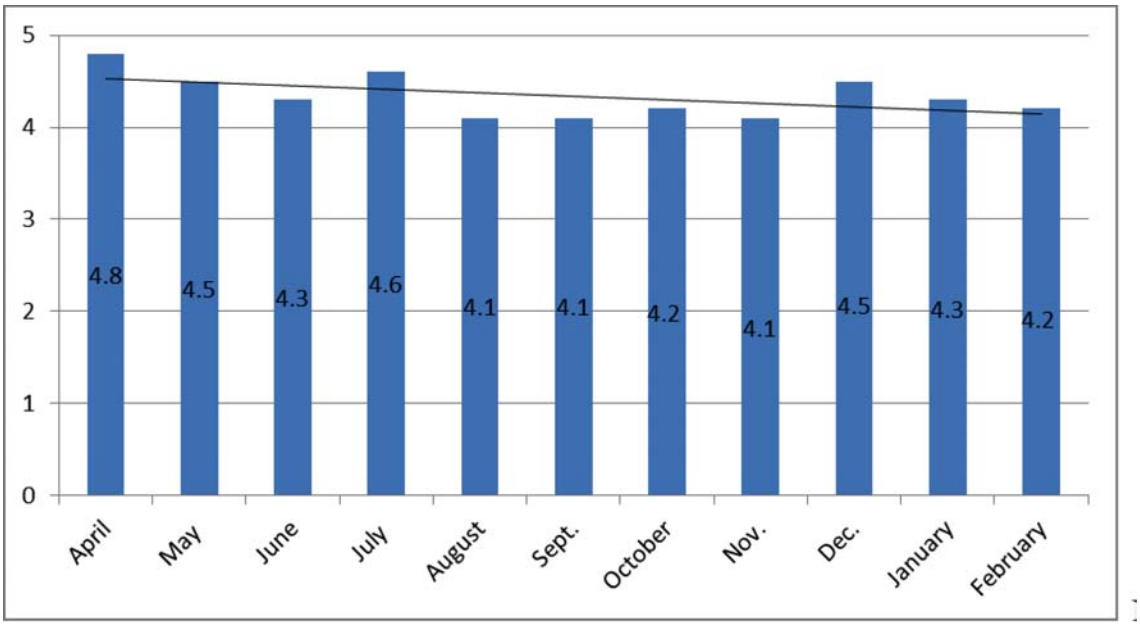
### 2.5 Post surgery infections
Reducing the number of infections that patients acquired following surgery.

The detail of our progress on our quality improvements in 2012-2013 is set out opposite:

## 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 - Percentage of patients who were readmitted 2012-2013**




Note 1: data for March 2013 not available to 1st June 2013

The straight line represents the trend in the data over the year. The graph shows that we have made progress in reducing the percentage of patients who are readmitted within thirty days of discharge from Poole Hospital. The improvement was achieved in the face of considerable pressures on hospital services and represents a year on year trend. Readmissions will continue as an area for further work.

**Improvement target achieved.**

## 2.2 Increasing the right patient in the right place at the right time

We set ourselves the target of seeking to place patients in a ward whose specialty matches their medical diagnosis. This ensures that the right expertise is more readily available and that staff do not have to move so often from one area to another. Table 2 shows the number of patients per day outlying in a ward outside their specialty

**Table 2 - Number of Patients Outlying their Specialty each day**


The straight line represents the trend in the data over the year. The graph shows that the Trust has not achieved this target despite its best endeavours. The target was set at 20 patients (in 605 beds) outlying their specialty but in the period November to March this target was missed by 8 patients per month on average.

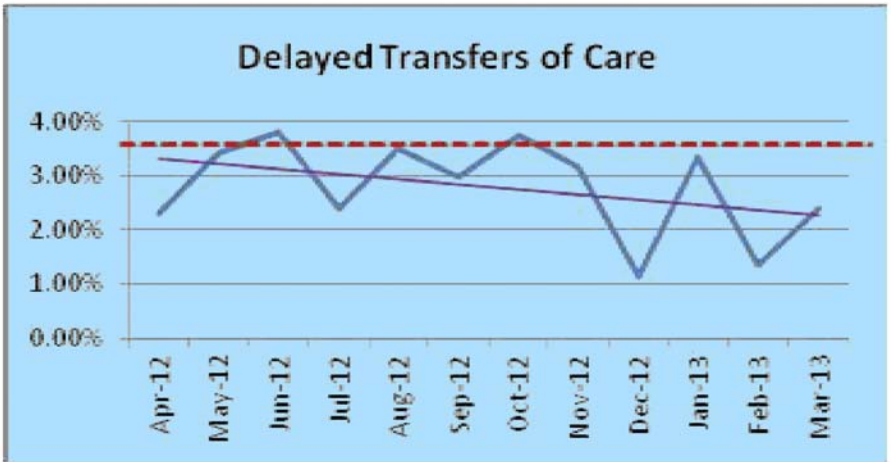
**Improvement target not achieved**

Progress on this target was hindered by a very busy winter where bed occupancy levels were very high. It will remain an improvement target for 2013-2014.

## 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 percentage of patients across the Trust whose discharge has been delayed.

**Table 3 - Percentage of patients whose onward care/discharge was delayed**



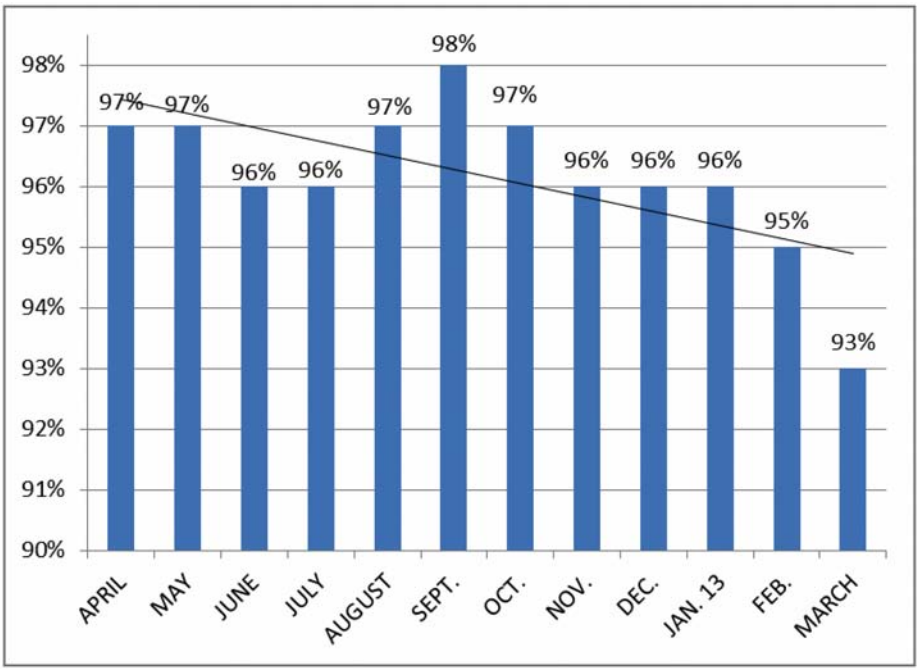

The straight line represents the trend in the data over the year. The graph shows that significant improvements have been made in this target. This improvement has been achieved through very good partnership working with other agencies meaning that patients were discharged in a more timely fashion without delays in over 97% of cases by March.

**Improvement target achieved.**

## 2.4 Accident and emergency

We set ourselves the target of increasing the percentage of people who are seen and treated within 4 hours in the Emergency Department of Poole Hospital reducing the waiting for patients. Table 4 shows the percentage of patients waiting less than 4 hours.

**Table 4 - Percentage of A&E patient waiting less than four hours**




The straight line represents the trend in the data over the year. The graph shows a reduction in the percentage of people dealt with within 4 hours although end of year performance is still around 93%.

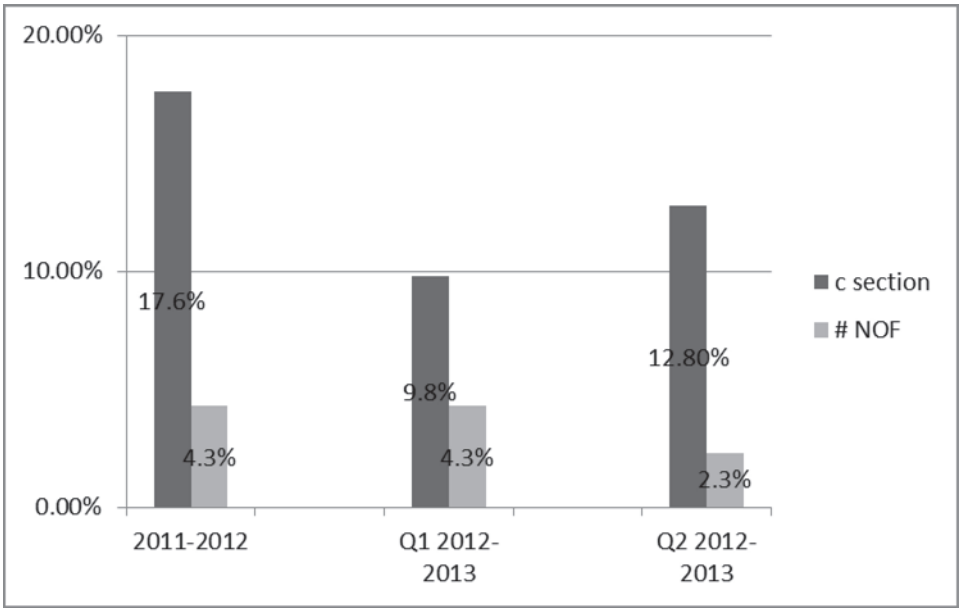
**Improvement target not achieved.**

The Trust plans to keep this as an improvement area in 2013-2014 to ensure consistent achievement.

## 2.5 Post-surgery infections

We set ourselves the target of reducing the post-operative infections following two key operations, caesarian section and fractured hip replacement. Table 5 shows the results of the audits of post-surgery infections carried out in the first six months of the year. Audits were not undertaken in the second six months of the year.

**Table 5 - Post-Operative Infection Rates Quarters 1 & 2**




Note 2: data was only collected for two quarters for these indicators to reduce the burden of audit for clinical staff.

**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 2013-March 2014). In selecting the areas for this years 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 2013-2014. The Board in consultation with the Council of Governors has deliberately continued to target two areas from the improvement targets in 2012-2013 to seek improvements in areas where the Trust did not succeed in the past year. Quality improvement remains a top priority for the Board of Directors.

The areas for improvement in 2013-2014 are:

### 3.1 Care of people with dementia

The Trust is committed to improving the care of patients who have a diagnosis of dementia. Improvements have been made to ward environments and the training of staff. The next step in this journey is to ensure that patients have a dementia assessment on admission.

### 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 Venous Thrombo Embolism (VTE)

Increasing the percentage of patients who have a VTE assessment on admission so that those patients who are at risk can receive appropriate care and treatment.

### 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 2013-2014.

### 3.5 Use of day theatres

Increasing the use of day theatres to maximise patient benefit and throughput

# 4. The details of our quality improvements for 2013/14

## 4.1 Priority 1

This priority for quality improvement is about caring for people who come into hospital and may have dementia.

### Description of the Issue

The number of people with dementia is increasing and it is known that early diagnosis and intervention can significantly help patients and their carers.

### Aim

To ensure patients over the age of over 75 years who are admitted to hospital have a documented dementia assessment

### Current Position

The current position for patient dementia assessments is unknown because it is a new initiative. This quality initiative will identify the baseline for the number of assessments and seek to ensure that 90% of over 75 year olds have an assessment by the end of March 2014.

### Actions to deliver this improvement

There are three key actions:

1. Agree an appropriate dementia assessment
2. Establish implementation programmes for introduction across divisions and clinical specialties
3. Audit completion of dementia assessment.

### Measurement, monitoring and reporting

All admitted patients are recorded on the hospital data system and as part of this system there will be an opportunity to confirm that a dementia assessment has been completed. As a cross check there will be clinical audits of patients to see that there is a completed dementia assessment. The data will be reported on a monthly basis to the Hospital Executive Group and the Board of Directors

**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. This is an important quality indicator because it indicates where a patient and their illness are matched to the nursing and medical teams in location. When patients are outlying the teams have to make extra journeys to visit them and there is a risk to patients. The Trust did not achieve the target it set itself last year and consequently renewed efforts will be made this year.

### 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

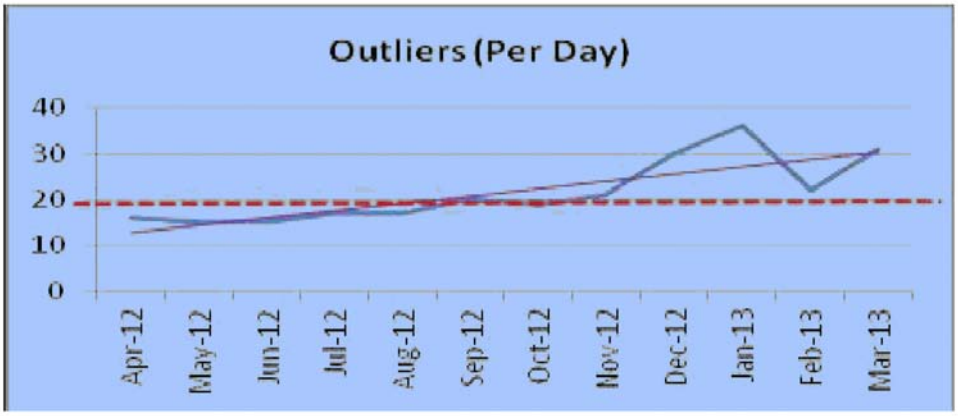
### Aim

To reduce the number of patients "outlying" in inappropriate wards.

### Current Position

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

### Table 6 - Number of Patients Outlying their Specialty each day




*Note 3: The straight line represents the trend in the data over the year*

### 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.

### Measurement, Monitoring and Reporting

All inpatient 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 and reported on a monthly basis to the Board of Directors.

**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 all admitted patients have an assessment for the risk of developing a venous thrombo embolism (VTE). VTE is a potentially fatal blood clot that can develop and pass through the body causing problems which can result in death of the patient.

### Description of Issue

The Trust has a target to undertake a VTE assessment on 95% of patients who are admitted to help reduce the risk of a patient subsequently developing an embolis (blood clot) and that becoming dislodged and causing major problems by blocking blood supply to a part of the body.

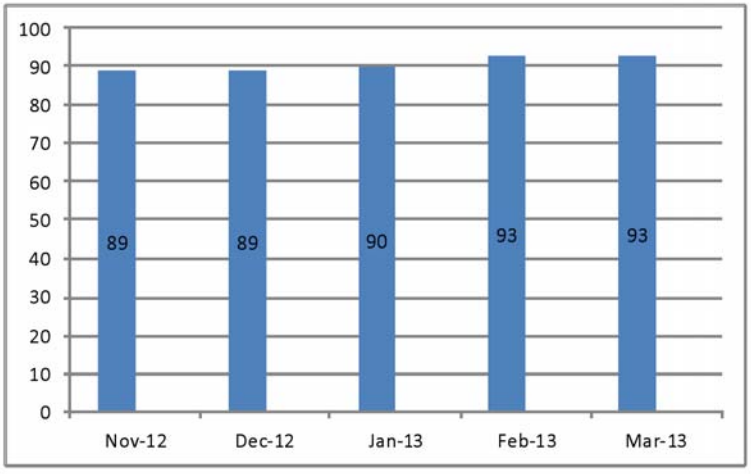
### Aim

To ensure that at least 95% of patients have a VTE assessment

### Current Position

The table below shows the percentage of patients who had a VTE assessment in 2012-2013.

### Table 7 - Percentage of Patients having a VTE Assessment




### Actions to Deliver this Improvement

1. VTE assessment part of the admission of the patient
2. Work with clinical teams to identify issues with assessment
3. Action plan on any issues to be resolved.
4. Performance monitoring

### Measurement, Monitoring and Reporting

All VTE assessments 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 and reported to the Board of Directors.

**Board Sponsor:** Medical Director
**Implementation Leads:** 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. This indicator was viewed as particularly important by the patients we talked to as they were keen to spend as less time as possible in the A&E department.

## 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.

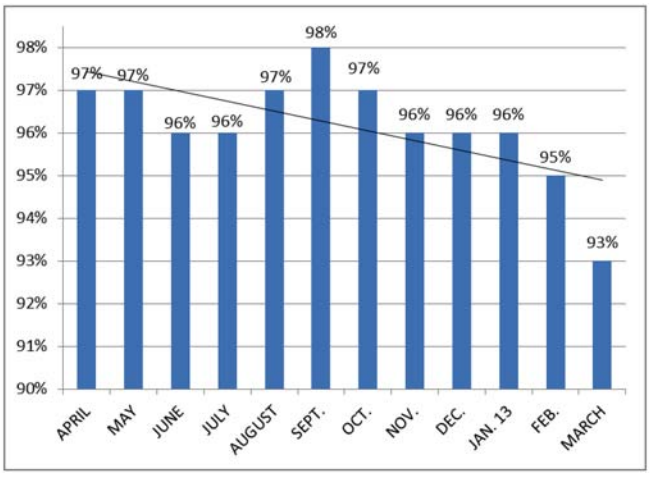
## Aim

To meet the A&E 4 hour target (95%) on average in each of the 4 quarters of 2013-2014 and increase the number of people who are seen and treated within 4 hours in the Emergency Department.

## 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 has periodically achieved the target. However the achievement is inconsistent as can be seen in the table below:

### Table 8 - Percentage of A & E patient waiting less than 4 hour




## Actions to Deliver this Improvement

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

## 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 the utilization of day theatres and seeks to improve the number of procedures that are undertaken on a day basis. This is important for patients because it indicates that the Trust has done all it can to reduce the need for patients to spend a night or more in hospital when the required procedure could be carried out on a day basis. The Council of Governors thought this was a key issue for patients.

### Description of Issue

There is a benefit to patients in having their surgery on a day basis rather than as an inpatient.

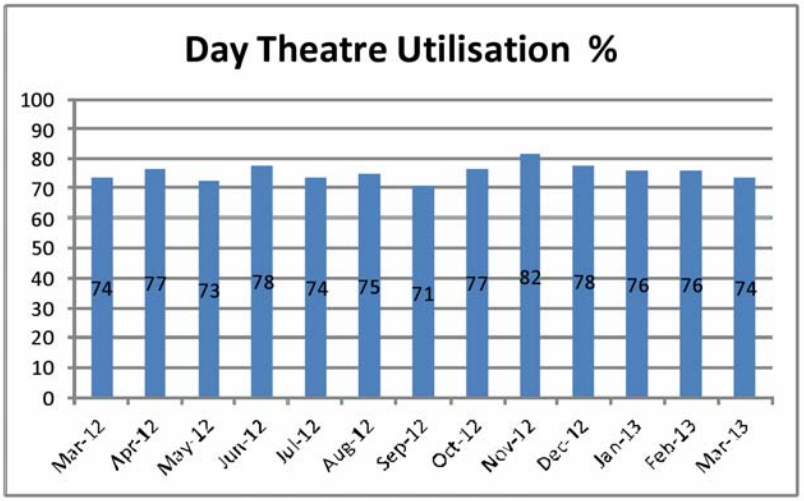
### Aim

Improve the day surgery utilization rate to achieve to 80% by March 2014.

### Current Position

The Trust's current day theatre ultilisation rate is recorded in table 9

### Table 9 - Day Theatre Utilisation Percentage




### Actions to Deliver this Improvement

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

### Measurement, Monitoring and Reporting

The day surgery rates will be scrutinised the Trust's Quality, Safety and Performance Committee and reported monthly to the Board of Directors.

**Board Sponsor:** Chief Operating Officer
**Implementation Leads:** Clinical Directors and Head of Theatres

## 4.6 Other Quality Improvements

Although this reports identifies five key improvement targets or the Trust there are over 50 other areas in which the Trust has set quality targets with the aim of improving the care and treatment that patients will receive. All of these targets will be monitored on a monthly basis.

# 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 2012-2013, 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 2012-2013 represents 100 per cent of the total income generated from the provision of these services.

## 5.2 Clinical Audits and National Confidential Enquiries

The following report provides information on national and local clinical audits as requested. As per the Clinical Audit Policy, the Trust states its intent to participate in national audits as below:

*"The Trust seeks as a priority to participate where applicable in all national audits approved by the National Advisory Group on Clinical Audit & Enquiries (NAGCAE)[1] . Where a national audit is not approved by the National Advisory Group on Clinical Audit & Enquiries (NAGCAE) participation is at the discretion of the specialty or the Lead Clinician for Clinical Audit".*

The above statement provides clarity regarding the Trust's intention to undertake national clinical audit, clearly identifying the master list of national audits and enables quarterly reporting of participation rates. The following information is based on this master list of national audits.

*[1] National clinical audits approved by NAGCAE include audits listed in the Quality Accounts as well as those listed within the National Clinical Audit Patient Outcome Programme.*

**Participation in Clinical Audits and National Confidential Enquiries**

During 2012/13, 35 national clinical audits covered NHS services that Poole Hospital provides and one national confidential enquiry.

During that period Poole Hospital participated in 100% of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Poole Hospital was eligible to participate in during 2012/13 are shown below:

| **Eligible and Participated** | |
|---|---|
| 1 | Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) |
| 2 | Adult Asthma |
| 3 | Adult community acquired pneumonia |
| 4 | Adult Critical Care (ICNARC CMP) |
| 5 | Blood sampling and labelling |
| 6 | Bowel cancer (NBOCAP) |
| 7 | Bronchiectasis |
| 8 | Cardiac Arrest (NCAA) |
| 9 | Cardiac Arrhythmia (HRM) |
| 10 | Diabetes (Adult) (ANDA) |
| 11 | Diabetes (Paediatric) (PNDA) |
| 12 | Elective surgery (National PROMs Programme) |
| 13 | Emergency use of oxygen |
| 14 | Epilepsy 12 (Childhood Epilepsy) |
| 15 | Fever in children |
| 16 | Fractured neck of femur |
| 17 | Head and neck oncology (DAHNO) |
| 18 | Heart failure (HF) |
| 19 | Hip fracture database (NHFD) |
| 20 | Inflammatory bowel disease (IBD) |
| 21 | Lung cancer (NLCA) |
| 22 | National Dementia Audit (NAD) |
| 23 | National joint registry (NJR) |
| 24 | Neonatal intensive and special care (NNAP) |
| 25 | Non-invasive ventilation |
| 26 | Oesophago-gastric cancer (NOGCA) |
| 27 | Paediatric asthma |
| 28 | Paediatric pneumonia |
| 29 | Pain Database |
| 30 | Parkinson's disease |
| 31 | Potential donor |
| 32 | Renal colic |
| 33 | Stroke National Audit Programme (SSNAP) |
| 34 | Trauma (TARN) |
| 35 | Use of Anti-D |
| 36 | Time to Intervene (National Confidential Enquiry) |

The national clinical audits that Poole Hospital participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

| Eligible and Participated | | Data collection completed in 2012/13 | % Cases Submitted | Comments |
|---|---|---|---|---|
| 1 | Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | Yes | No formal case ascertainment rates have been published. The number of Poole cases for this audit is small and anything appropriate for MINAP is submitted via Royal Bournemouth Hospital. | |
| 2 | Adult Asthma | Yes | 100% | |
| 3 | Adult community acquired pneumonia | Yes | 100% | |
| 4 | Adult Critical Care (ICNARC CMP) | Yes | Not appropriate to calculate case ascertainment rates due to the nature of the project. | |
| 5 | Blood sampling and labelling | Yes | 100% | |
| 6 | Bowel cancer (NBOCAP) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 7 | Bronchiectasis | Yes | 100% | |
| 8 | Cardiac Arrest (NCAA) | Yes | Not appropriate to calculate case ascertainment rates due to the nature of the project. | |
| 9 | Cardiac Arrhythmia (HRM) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 10 | Diabetes (Adult) (ANDA) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 11 | Diabetes (Paediatric) (PNDA) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 12 | Elective surgery (National PROMs Programme) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 13 | Emergency use of oxygen | Yes | 9 wards | The minimum cohort for this project was 1 ward. |
| 14 | Epilepsy 12 (Childhood Epilepsy) | No | Deadline for data submission June 2014. | |
| 15 | Fever in children | Yes | 100% | |
| 16 | Fractured neck of femur | Yes | 100% | |
| 17 | Head and neck oncology (DAHNO) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 18 | Heart failure (HF) | Yes | 146.2% | Calculation of case ascertainment rate is estimated |

| | | | | |
|---|---|---|---|---|
| 19 | Hip fracture database (NHFD) | Yes | 97.2% | |
| 20 | Inflammatory bowel disease (IBD) | No | Deadline for data submission December 2013. | |
| 21 | Lung cancer (NLCA) | Yes | 103% | Calculation of case ascertainment rate is estimated against historic cancer registry returns. |
| 22 | National Dementia Audit (NAD) | Yes | 100% | |
| 23 | National joint registry (NJR) | Yes | 33% | 33% reported based on HES/PEDW data. TAC Team has robust data collecting / reporting systems in place therefore true case ascertainment rate is thought to be significantly higher. |
| 24 | Neonatal intensive and special care (NNAP) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 25 | Non-invasive ventilation | Yes | 100% | |
| 26 | Oesophago-gastric cancer (NOGCA) | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 27 | Paediatric asthma | Yes | 100% | |
| 28 | Paediatric pneumonia | Yes | Awaiting national report to confirm formal case ascertainment rate. | |
| 29 | Pain Database | Yes | 100% | |
| 30 | Parkinson's disease | Yes | 100% | |
| 31 | Potential donor | Yes | Not appropriate to calculate case ascertainment rates due to the nature of the project. | |
| 32 | Renal colic | Yes | 100% | |
| 33 | Stroke National Audit Programme (SSNAP) | No | Deadline for data submission 10th May 2013 for the first quarterly report (covers period 1st Jan to 31st Mar 2013) | |
| 34 | Trauma (TARN) | Yes | 25% | During 2012 there were no staff funded or in post to complete the audit information and upload data to the national database. This has now been addressed and a dedicated post created to ensure data is now added to TARN for 2013. 2012 data will continue to be added retrospectively to TARN. |
| 35 | Use of Anti-D | No | Data collection for this project has been delayed until June 2013 | |

The reports of 36 national clinical audits were reviewed by the provider in 2012/13 and Poole Hospital intends to take the following actions to improve the quality of healthcare provided.

**National Clinical Audits Reviewed in 2012/13 and Local Action Plans - 1**

| No | Title | Actions being taken |
|---|---|---|
| 1 | National Neonatal Audit Programme (NNAP) (1st January 2010 to 31st December 2010) | 1. To improve the quality of data input on the Standardised Electronic Neonatal Database (SEND). |
| 2 | National British Thoracic Society (BTS) Paediatric Asthma Audit (1st November 2011 to 30th November 2011) | No local action plan required. |
| 3 | National Audit of the Management of Severe Sepsis and Septic Shock in Adults (1st August 2011 to 31st January 2012) | 1. To remind all staff to use the College of Emergency Medicine (CEM) sepsis proforma. |
| 4 | The National Heart Failure Audit and Meeting National Standards (1st April 2010 to 31st March 2011) | 1. Employment of an in-patient heart failure nurse if possible. |
| 5 | Myocardial Infarction National Audit Project (MINAP) (1st April 2010 to 31st March 2011) | No local action plan required. |
| 6 | National Audit of Bronchiectasis (1st October 2011 to 30th November 2011) | 1. To present the findings of the audit to the department.<br>2. To discuss with management the possibility of establishing a Bronchiectasis Clinic. |
| 7 | National Audit of Non Invasive Ventilation (Adults) (1st February 2012 to 31st March 2012) | 1. To prepare new non-invasive ventilation guidelines. |
| 8 | National Bowel Cancer Audit: 2010 Annual Report (1st August 2008 to 31st July 2009) | No local action plan required. |
| 9 | National Bowel Cancer Audit: 2011 Annual Report (1st August 2009 to 31st July 2010) | 1. To review the number of patients with rectal cancer.<br>2. To review the patients with rectal cancer not receiving a MRI scan. |
| 10 | National Audit of Seizure Management in Hospitals (from 1st October 2010) | 1. Re-audit of the current Emergency Department process. |
| 11 | Epilepsy 12 National Audit (from 1st May 2011) | 1. Decrease waiting times for Paediatric Epilepsy Clinic by increasing capacity (at least 2 secondary care clinics per week) to ensure timely review of patients by consultant with expertise in epilepsy.<br>2. To appoint a paediatric epilepsy nurse.<br>3. Take steps (including above) to meet best practice tariff (BPT) standards.<br>4. To present the findings of the audit at the next Child Health clinical governance meeting. |

Continued on next page

## National Clinical Audits Reviewed in 2012/13 and Local Action Plans - 2

| | | |
|---|---|---|
| 12 | National Neonatal Audit Programme (NNAP) (1st January 2011 to 31st December 2011) | 1. To improve data input in SEND, with daily checks. |
| 13 | National British Thoracic Society (BTS) Paediatric Pneumonia (1st November 2011 to 31st January 2012) | No local action plan required. |
| 14 | TARN Severe Trauma (1st January 2011 to 31st December 2011) | 1. To increase data submitted. |
| 15 | National Audit of the Management of Pain in Children in the Emergency Department (1st August 2011 to 31st January 2012) | 1. To undertake training of medical and nursing staff on importance of analgesia and documentation.<br>2. To consider modification of documentation. |
| 16 | National Cardiac Rhythm Management UK Clinical Audit (1st January 2010 to 31st December 2010) | No local action plan required. |
| 17 | National UK Inflammatory Bowel Disease (IBD) Audit (1st October 2010 to 31st August 2011) | No local action plan required. |
| 18 | National Audit of Adult Community Acquired Pneumonia (1st December 2011 to 31st January 2012) | 1. To discuss the audit findings with the acute physicians.<br>2. To present the audit findings at the next clinical governance meeting. |
| 19 | National NCASP Diabetes Audit - Adults (1st September 2010 to 31st August 2011) | No local action plan required. |
| 20 | National Audit of the Organisation of Services for Falls & Bone Health for Older People (1st April 2010 to 31st July 2010) | No local action plan required. |
| 21 | Stroke Improvement National Audit Programme (SINAP) (1st January 2011 to 31st December 2011) | 1. To submit a business case for 7 day a week consultant and therapist cover on the stroke unit.<br>2. To provide training of stroke unit nurses in swallow screening.<br>3. To use continence assessment form.<br>4. To undertake a review of acute integrated care pathway (ICP) with regard to fluid provision. |
| 22 | Parkinson's UK: National Parkinson's Audit (1st July 2011 to 30th November 2011) | No local action plan required. |
| 23 | Intensive Care National Audit and Research Centre (ICNARC): Case Mix Programme (1st April 2010 to 31st March 2011) | 1. To ensure awareness of this long term problem (numbers of delayed discharges from the Critical Care Unit) with the Clinical Management Team.<br>2. Review and discussion of outliers within the audit findings.<br>3. Continued participation with the ICNARC project. |

Continued on next page

## National Clinical Audits Reviewed in 2012/13 and Local Action Plans - 3

| | | |
|---|---|---|
| 24 | National Audit of Heavy Menstrual Bleeding (1st February 2011 to 31st January 2012) | No local action plan required. |
| 25 | The European Chronic Obstructive Pulmonary Disease (COPD) Audit (25th October 2010 to 19th December 2010) | No local action plan required. |
| 26 | The National Heart Failure Audit and Meeting National Standards (1st April 2011 to 31st March 2012) | 1. To appoint in-patient heart failure nurse and new consultant. |
| 27 | NHS Blood and Transplant: Potential Donor Audit (1st April 2011 to 31st March 2012) | No local action plan required. |
| 28 | The National Hip Fracture Database (NHFD): National Report 2012 (1st April 2011 to 31st March 2012) | 1. To produce a daily "Trauma Report" which reports the neck of femur breaches against the NHFD and Primary Care Trust targets.<br>2. The Trauma Improvement Group meets on a monthly basis and as part of their remit the results from this national audit are reviewed and action taken as appropriate. At the next meeting the results against standard 1 (All patients with hip fracture should be admitted to an acute orthopaedic ward within 4 hours of presentation) will be reviewed and any appropriate action to be taken decided.<br>3. To introduce an Orthogeriatric service that operates a 7-day a week service. |
| 29 | National Pain Database Audit: Chronic Pain Services (28th April 2011 to 29th July 2011) | No local action plan required. |
| 30 | National Joint Registry (NJR): 9th Annual Report (1st April 2011 to 31st March 2012) | No local action plan required. |
| 31 | National Re-audit of the Management of Renal Colic Within the Emergency Department (1st August 2012 to 30th November 2012) | 1. To develop renal colic proforma.<br>2. Ensure pain relief and reassessment target times are incorporated into proforma. |
| 32 | Myocardial Ischaemia National Audit Project (MINAP) (1st April 2011 to 31st March 2012) | No local action plan required. |
| 33 | British Thoracic Society (BTS) Emergency Oxygen Audit (15th August 2012 to 1st November 2012) | 1. To take the results back to the Oxygen Group and discuss at the Respiratory Department meeting.<br>2. To introduce red stickers for the drug charts to prompt compliance with the expected standards. |
| 34 | National Head and Neck Cancer Audit (DAHNO): 7th Annual Report (1st November 2010 to 31st October 2011) | 1. To present and discuss the local results from the DAHNO 7th Annual Report at the Head & Neck Education meeting post Network Site Specific Group meeting.<br>2. To prepare a business case in order to apply for administrative support for the data entry requirements of the Somerset System / DAHNO for the Clinical Nurse Specialists, Dietitians and Speech & Language Therapists.<br>3. To routinely record patient performance status and co-morbidity in the data recorded on the multi disciplinary team (MDT) proforma during the Head & Neck MDT meetings. |

Continued on next page

## National Clinical Audits Reviewed in 2012/13 and Local Action Plans - 4

| | | |
|---|---|---|
| 35 | National Bowel Cancer Audit: 2012 Annual Report (1st August 2010 to 31st July 2011) | No local action plan required. |
| 36 | National Lung Cancer Audit: 2012 Annual Report (1st January 2011 to 31st December 2011) | 1. To request CT scans prior to the clinic appointment.<br>2. To undertake a local audit of CT scan wait times. |

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

| No. | Title |
|---|---|
| 1 | National Elective Surgery Patient Reported Outcome Measures (PROMs) (1st April 2010 to 31st March 2011) |
| 2 | National Audit of Bronchiectasis (1st October 2012 to 30th November 2012) |
| 3 | National British Thoracic Society (BTS) Adult Asthma Audit (1st September 2012 to 31st October 2012) |
| 4 | National Re-audit of Feverish Children - College of Emergency Medicine (CEM) (1st August 2012 to 30th November 2012) |
| 5 | Re-audit Fractured Neck of Femur - College of Emergency Medicine (CEM) (1st August 2012 to 30th November 2012) |
| 6 | National Cardiac Rhythm Management UK Clinical Audit (1st January 2011 to 31st December 2011) |
| 7 | National Comparative Audit of the Medical Use of Blood (1st September 2011 to 30th November 2011) |
| 8 | TARN Severe Trauma (1st January 2012 to 31st December 2012) |
| 9 | National Audit of Dementia - Spring 2012 (1st September 2011 to 29th February 2012) |
| 10 | National Comparative Audit of the Labelling of Blood Samples for Transfusion (1st May 2012 to 31 July 2012) |

The reports of 123* local clinical audits were reviewed by the provider in 2012/13 and Poole Hospital intends to take the following actions to improve the quality of healthcare provided:

*Of the 123 local clinical audits reviewed, 34 identified that change in practice was not required due to good performance.

Of the remaining 89, Poole Hospital has undertaken actions to improve the quality of healthcare provided. Below are a number of examples:

### 1. Develop new and improve existing patient information

- Introduction of the SAFER leaflet (NHS Diabetes) for female diabetes patients of childbearing age.
- The "Being Admitted to Hospital" national leaflet has been made available in the Children's Outpatient Department.

**2. Improve the education and training of new as well as existing staff**

- A handbook for all new medical staff in Surgery has been developed which covers the topic of clinically appropriate pre-operative testing. It is hoped that this will help to reduce pre-operative over testing.
- Educational initiatives have been undertaken in Maternity to ensure that all staff are aware of expectations in the use of patient identification bands.
- Posters have been put up in the clinic rooms within the Diabetes Centre to remind medical staff of the importance of fully documenting all drugs, including contraception medication, and also to prompt all staff to discuss pregnancy and contraception with female patients.
- Laminated absolute risk charts are now available in all clinic rooms within the Diabetes Centre for HbA1c and congenital anomalies.
- Teaching on record keeping expectations has been included in the foundation doctors' educational programme.
- The Outreach Service has set-up twice weekly educational sessions for ward staff, covering topics relating to the care of the acutely ill patient.
- The Acute Illness Management study day is now a mandatory requirement for all nursing auxiliaries.
- Inclusion of malnutrition screening training in the nurse induction and ward training programme.
- Training sessions on nutritional screening, oral nutrition support, enteral and parenteral nutrition have been delivered to the junior doctors.
- A trust-wide Nutritional Awareness Day has been undertaken by the Dietetic Department.
- Training sessions on urinalysis are in place within the Emergency Assessment Unit.
- Posters on the disposal of controlled drugs have been developed and are displayed on the controlled drug cupboards.
- A programme of training staff in mattress care and cleaning has been developed and provided.
- Acute kidney injury (AKI) management teaching programme undertaken for nursing and medical staff.
- Quarterly newsletter produced and circulated in order to communicate orthopaedic surgery surveillance data and information / updates to all orthopaedic staff.

**3. Develop new and update existing local policy and guidance documents**

- Production of a new procedure care booklet, which includes a post-care template, for the care of patients undergoing imaged-guided or assisted liver biopsy.
- A laminated sheet has been put in all of the doctors rooms in the Child Health Department to remind medical staff of the documentation requirements for prescriptions.
- Easily accessible guidelines on the completion of inpatient discharge summaries have been published on the local intranet.
- The Poole Early Warning System (PEWS) and Observation Policies have both been reviewed and updated and are available on the local intranet.
- Oral Maxillofacial (OMF) Junior Doctor Handbook developed including incorporation of "Standards of Written Record Keeping for Medical Staff".
- The Policy for Prescribing Vancomycin has been re-written and includes a new

prescription proforma.
- The Oxygen Policy has been developed and introduced. An oxygen administration flowchart has been given to all junior doctors and placed by all oxygen points.
- Transfusion Guidelines for Patients with Acute Gastrointestinal Bleed have been approved and introduced.
- Renal Replacement Therapy (RRT) Guidelines have been developed and introduced.
- The Delayed and Omitted Doses Policy has been approved including criteria for reporting missed doses via AIRS forms.

**4. Develop new and improve existing local proforma / charts / forms**

- Implementation of a new online proforma for the documentation of management of operative vaginal deliveries, including data items relating to bladder emptying. There are also certain mandatory fields on this proforma that assists with meeting the requirements of the Clinical Negligence Scheme for Trusts (CNST).
- A new risk assessment tool for the assessment of stroke patients with atrial fibrillation has been trialled.
- A link has been placed on the local intranet to the Malnutrition Universal Screening Tool (MUST) calculator.
- Medical pain assessment charts have been instigated on the paediatric assessment ward. Also, a surgical pain assessment chart is now included in all paediatric ENT, Surgical and Orthopaedic admission packs.
- A new proforma has been introduced to facilitate improved referrals for MRI scan following suspected scaphoid facture.
- The urinalysis algorithm has been updated and simplified.
- A chest drain proforma has been developed to assist improvements in the insertion, as well as the daily management of, chest drains.
- The addition of a "Stop Before you Block" reminder on the Surgical Safety Checklist.
- Investigation packs for anaphylaxis following anaesthesia have been introduced in all main recovery areas as well as the Critical Care Unit.
- "Do not Attempt Resuscitation" (DNAR) charts have been updated to improve the documentation of DNAR decisions.
- A Nursing Trauma Admission Booklet has been developed to reduce duplication of paperwork and minimise potential for errors.
- A revised proforma for medical reports submitted towards statementing of children with special educational needs has been developed and rolled out to ensure uniformity of reporting.
- To support foot assessment of patients with diabetes, the medical clerking proforma has been updated to include a question on foot examination.

**5. Updates to local clinical working practice**

- Local practice has been amended in the use of extrinsic sealants in the production of prostheses in order to reduce the numbers of premature prosthesis replacements due to discolourations.
- A new standard system for documentation by the Dieticians in the main medical notes has been developed.
- Warming devices and temperature monitoring has been introduced in the

Maternity Theatres for obstetric patients to aid the prevention of surgical site infections.
- Tympanic membrane thermometers are available in every anaesthetic room and operating room to minimise the risk of inadvertent perioperative hypothermia.
- In Main and Day Theatres, ranger fluid warmers are applied to allow perioperative warming of IV fluids to minimise the risk of inadvertent perioperative hypothermia.
- Improved accessibility to the CT scanner supporting timely scanning of trauma patients.
- Storage and timely access to replacement mattress has been improved.
- Consultants now transport bone marrow to blood transfusions double bagged with a completed transportation form.
- To increase radiotherapy planning accuracy, all head and neck patients are now being imaged with kilovoltage instead of megavoltage.

## 5.3 Clinical research

Poole Hospital encourages all staff to get involved in research as part of a commitment to continuous improvement. The number of patients receiving NHS services provided by Poole Hospital in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 1895 (non-commercial, commercial and educational studies).

Participation in clinical research demonstrates Poole Hospital's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Poole Hospital was involved in conducting 194 clinical research studies during 2012/13 in the following specialties:
- Age and aging
- Anaesthetics
- Cancer: brain; breast; colorectal; gynaecology; head and neck; lung; lymphoma; melanoma; renal; upper GI; urology; paediatrics; haematology.
- Medicines for children
- Critical care
- Dermatology
- Diabetes
- Emergency Medicine
- Gastroenterology
- Health Service Research
- Hepatology
- Maternity
- Musculoskeletal
- Neurology
- Occupational therapy
- Orthopaedics
- Physiotherapy
- Radiology
- Respiratory
- Rheumatology
- Stroke
- Surgery

There was 17 whole time equivalent (WTE) clinical staff participating in research approved by a research ethics committee at Poole Hospital during 2012/13. These staff participated in research covering 22 medical specialties. 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 2012-2013 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 2012-2013 this was equivalent to £2.5 million which was paid to the Trust in full as part of the contractual arrangements. Further details of the agreed goals for 2012-2013 and for the following twelve month period (2013-2014) 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 2012-2013.
- 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 2012 to 31st March 2013.
- The Trust had an unannounced inspection by the CQC in July 2012. Five outcome areas were considered and the Trust was found to be compliant in four areas and the CQC found a further area where the Trust was not meeting an element (Do Not Attempt Resuscitation) of the standard which they said had a minor impact on patients. Following the implementation of a detailed action plan the Trust was re-inspected in December 2012 and the CQC found that the standard had been met.

## 5.6 Data Quality

- Poole Hospital NHS Foundation Trust submitted records during 2012-13 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 2013.

- The percentage of records submitted which included the patient's valid NHS number was (national averages are shown in brackets):
  99.5% (99.1%) for admitted care
  99.8% (99.3%) for outpatient care
  97.7% (94.9%) for accident and emergency care
- The percentage of records submitted data which included the patient's General Practitioner practice code was:
  100% (99.9%) for admitted care
  100% (99.9%) for outpatient care
  100% (99.7%) for accident and emergency care
- Poole Hospital NHS Foundation Trust's Information Governance Assessment Report overall score for 2012-2013 was 60% and was graded as amber (unsatisfactory).
- 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 has not been subject to a full Payment by Results data assurance framework (clinical coding) audit this year as quality is regarded as high given the results of previous audits. The SUS data quality dashboard confirms however that the accuracy and completeness of clinical coding within admitted patient care records submitted over the eleven months continues to compare favourably with national averages (shown in brackets) as follows:
  99.6% (98.5%) for primary diagnosis
  100% (99.9%) for primary procedure

*Notes regarding section 5.6*
*Note 5 - These results should not be extrapolated further than the actual sample audited.*
*Note 6 - All services have been reviewed within the sample.*
*Note 7 - Data quality is subject to regular audits and any identified actions to improve data quality will be taken by the Trust*

# Part 3 - Review of Quality Performance

## 6. What patients and the public have said

- The Trust participated in one national survey during the course of the year, the National Inpatient Survey, but also received the results of two national surveys, Accident & Emergency Department Survey and the National Cancer Experience Programme Survey.

- The National Inpatient Survey sought the views of 850 inpatients of the Trust in the autumn of 2012. The Trust was just one of five non specialist acute Trusts in the country to score the best performing trusts in the country on two or more sections. Of particular pleasure for the Trust was the patients rating of nurses which was one of the highest in the country.

- The National Accident & Emergency Department Survey sought the views of 820 patients attending the A&E Department of the Trust in the winter/spring of 2012. Patients' rated care at 79% for overall care and 89% for privacy and dignity placing the Trust on the margins of the best performing trusts

- The National Cancer Experience Survey reported 94% of patients rated their care as 'excellent' or 'very good', giving Poole the highest score recorded amongst participating trusts. In 40 out of 70 questions asked (57%), the responses from patients regarding their care at Poole Hospital were in the highest scoring 20% of all trusts in the country; none were in the lowest scoring 20%.

## 7. Performance against selected measures

- The Trust has selected a number of measures to indicate what progress has been made during 2012-2013 in three key areas, patient safety, clinical effectiveness and patient experience. The reported areas have remained the same as in the last 3 years Quality Report to provide the reader with a view of performance over several years. They 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. In the final column of each table the data source is identified.

## 7.1 Patient safety

| MEASURE | 2012-2013 | 2011-2012 | 2010-2011 | 2009-2010 | Data Source |
|---|---|---|---|---|---|
| Hospital acquired MRSA bacteraemia | **4** | 1 | 4 | 0 | National |
| Hospital acquired pressure ulcer Grade 3 or Grade 4 | **12** | 4 | 7 | 16 | Local |
| Patient falls from bed or trolley (Note 8) | **15** | 28 | 18 | 46 | Local |

*Note 8: Quarter 4 data only*

The number of MRSA bacteraemias was disappointing but within the tolerance limit of the foundation trust regulator. Three of the four cases were unavoidable. Acquired pressure sores reflect the increasing sickness of admitted patients and it is worth noting that there were no grade 4 acquired pressure ulcers. Falls form bed or trolley has improved but may reflect again the increasing sickness levels of admitted patients.

## 7.2 Clinical effectiveness

| MEASURE | 2012-2013 | 2011-2012 | 2010-2011 | 2009-2010 | Data Source |
|---|---|---|---|---|---|
| Hospital mortality rate (figure in brackets is expected levels) (Note 9) | **92.1% (100%)** | 75.6% (100%) | 108.2% (100%) | 101.6% (100%) | National |
| Cancelled operations not readmitted within 28 days | **0%** | 0% | 0% | 0% | National |
| Stroke high risk patients treated in 24 hours (45% target) | **43%** | 80% | 80% | 85% | National |

Note 9: Expected figure derived from Dr Foster data and is standardised for a number of factors. Reporting from 2012-2013 is by relative risk compared to national figures rather than the actual rate. The rate is the latest available which is January 2013
Mortality rates continue below national averages which is positive. There is work to be done in rapid treatment of patients with the diagnosis of stroke.

## 7.3 Patient experience

| MEASURE | 2012-2013 | 2011-2012 | 2010-2011 | 2009-2010 | Data Source |
|---|---|---|---|---|---|
| Overall patient satisfaction rated excellent or very good (Note 10) | **81%** | 83% | 81% | 81% | National |
| Patient Environment Action Team (PEAT) Inspection Report and Patient Led Assessment of the Care Environment (PLACE) (Note 11) | **tbc** | Excellent (environment) Good (food) Excellent (privacy & dignity) | Excellent (environment) Good (food) Excellent (privacy & dignity) | Excellent (environment) Excellent (food) Excellent (privacy & dignity) | National |
| Patient rating of privacy and dignity (inpatient) (Note 9) | **92%** | 84% | 84% | 82% | National |

*Note 10: the wording of the national inpatient surveys changed in 2012. Note 11: PLACE replaced PEAT in 2013*

Patients rating of privacy and dignity has significantly improved.

# 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. The Trust has tried to replicate its reporting year on year to provide readers with a consistent view. Other key indicators are described in section 8.2. All these data items are nationally collected and to prescribed national definitions.

### Table 14 - National Target Performances

| | Target Description | 2012-2013 | 2011-2012 | 2010-2011 | Target Figure (2012-2013) |
|---|---|---|---|---|---|
| 8.1.1 | Care Quality Commission Standards/Regulated Activities | **16/16** | 16/16 | 16/16 (regulated activities) | 16 |
| 8.1.2 | Clostridium Difficile Infections | **27 (5 samples on 2 patients)** | 24 | 42 | 25 |
| 8.1.3 | MRSA bacteraemias (bloodstream infections) | **4** | 1 | 4 | 1 |
| 8.1.4 | Maximum 31 day cancer first treatments | **100%** | 100% | 100% | 96% |
| 8.1.5 | Maximum 62 day cancer treatments (note 12 month average) | **97%** | 90% | 94% | 85% |
| 8.1.6 | 18 week maxim um wait (admitted patients) | **98%** | 93% | 95% | 90% |
| 8.1.7 | 18 week maxim um wait (non-admitted patients) | **97%** | 97% | 98% | 95% |
| 8.1.8 | Less than 4 hour wait i n A&E | **95%** | 96% | 99% | 95% |
| 8.1.9 | 31 days to subsequent treatment for all cancers | **100%** | 99% | 95% | 94% |
| 8.1.10 | 62 days urgent referral to treatment for all cancers | **88%** | 90% | 94% | 85% |
| 8.1.11 | Thrombolysis within 60 minutes | **100%** | 100%* | 75% | 68% |
| 8.1.13 | Cancer two week wait all cancers | **97%** | 96% | 97% | 93% |
| 8.1.14 | Cancer two week wait breast cancer | **94%** | 100% | 100% | 93% |

*Note 12: 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.*

| PRESCRIBED INDICATOR | NATIONAL AVERAGE 2011/2012 | PHT POSITION 2011/2012 | COMPARISION WITH OTHER TRUSTS | NATIONAL AVERAGE 2013/2013 | PHT POSITION 2012/2013 | COMPARISION WITH OTHER TRUSTS |
|---|---|---|---|---|---|---|
| | | | | | | |
| - **Summary hospital level mortality indicator (SHM1)** | 1.00 | 0.91 | Better than average Highest 1.16 Lowest 0.68 | 1.00 | 0.91 | Better than average Highest 1.21 Lowest 0.76 |
| Poole Hospital NHS Foundation Trust considers that this data is as described because of the excellent work of clinical staff | | | | | | |
| Poole Hospital NHS Foundation Trust will continue the work on improving mortality that it already undertakes | | | | | | |
| - **Percentage of patient deaths with palliative care coded at either diagnosis or specialty level** | N/A | 24.4% | Highest 44.2% Lowest 4.9% | N/A | 24.4% | Highest 41.9% Lowest 7.9% |
| Poole Hospital NHS Foundation Trust considers that this data is as described because of the excellent work of clinical staff. The data is presented as available from the national database. | | | | | | |
| Poole Hospital NHS Foundation Trust will continue the work on improving mortality that it already undertakes | | | | | | |

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| | | | | | | |
|---|---|---|---|---|---|---|
| - **Patient reported outcome score for groin hernia surgery** | N/A | 74.6% | N/A<br>Highest 95%<br>Lowest 69% | N/A | 81.5% | N/A<br>Highest 94%<br>Lowest 65% |
| Poole Hospital NHS Foundation Trust considers that this data is as described because of the very small numbers of patients having this procedure at the Trust. | | | | | | |
| Poole Hospital NHS Foundation Trust will continue to seek to improve patients responding to the questionnaire on their satisfaction | | | | | | |
| - **Percentage of patients readmitted to hospital within 28 days of being discharged**<br>**4.1 0 to 14 years old**<br>**4.2 15 years old and over** | N/A | <br>3.0%<br>4.0% | N/A | N/A | <br>4.3%<br>4.4% | N/A |
| Poole Hospital NHS Foundation Trust considers that this data is as described because the data has been internally validated. | | | | | | |
| Poole Hospital NHS Foundation Trust will be working across the health and social care community to reduce unnecessary patient readmissions | | | | | | |
| - **Percentage of staff who would recommend the Trust as a provider of care to their family or friends** | 71% | 67% | Slightly worse than average<br>Highest N/A<br>Lowest N/A | 71% | 70% | About the same as average<br>Highest N/A<br>Lowest N/A |

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| | | | | | | |
|---|---|---|---|---|---|---|
| Poole Hospital NHS Foundation Trust considers that this data is as described because the question is doubled barrelled and asks about both staff and patients. | | | | | | |
| Poole Hospital NHS Foundation Trust will be asking both staff and patients about whether they recommend the Trust in future responding to the questionnaires | | | | | | |
| - **Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism** | N/A | 90% | N/A | N/A | 94% | N/A |
| Poole Hospital NHS Foundation Trust considers that this data is as described because of the good work being undertaken by clinical staff. | | | | | | |
| Poole Hospital NHS Foundation Trust will continue the work on improving VTE assessment that it already undertakes | | | | | | |
| - **Rate per 100,000 bed days of cases of c.difficile infection amongst patients aged 2 or over** | 21.8 | 13.6 | Significantly better than others Highest 50.9 Lowest 7.2 | N/A | N/A<br><br>Highest N/A Lowest N/A | N/A |

Table continued on next page

| | | | | | | |
|---|---|---|---|---|---|---|
| Poole Hospital NHS Foundation Trust considers that this data is as described because of the excellent work in preventing infections in the Trust. There were no cases of C.Diff cross contamination in either year. | | | | | | |
| Poole Hospital NHS Foundation Trust will continue the work on improving infection prevention that it already undertakes. | | | | | | |
| - **Number of patient safety incidents** | N/A | 3,920 | N/A | N/A | 4,062 | N/A |
| **Percentage rate of patient safety incidents per 100 admissions** | N/A | 10.47% | Highest 10.47% Lowest | N/A | 11.05% | Highest 14.44% Lowest 3.11% |
| **Percentage rate of severe harm or death** | 0.8% | 0.4% | Highest 1.9% Lowest 0.0% | 0.9% | 0.2% | Highest 3.6% Lowest 0.1% |
| Poole Hospital NHS Foundation Trust considers that this data is as described because of the open reporting culture and encouragement to staff in the Trust. The degree of harm caused to patients is very low. It should be noted that this data is for the six month period April to September each year. | | | | | | |
| Poole Hospital NHS Foundation Trust will continue to promote and support an open reporting culture in the Trust | | | | | | |

Table notes overleaf

**Note 13: Patient safety incidents resulting in severe harm or death**
*This year is the first time that this indicator has been required to be included within the Quality Report alongside comparative data provided, where possible, from the Health and Social Care Information Centre. The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS Trusts to reports patient safety incidents under the NRLS's voluntary arrangements. The figure for annual incident reports to the NRLS for 2012-13 is 8,277 (subject to ratification) of these 21 rated severe.*

*As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the Trusts as this may not be comparable.*

# 9. Other quality improvements

During 2012-2013 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 Ward Refurbishment
The Trust's ward refurbished programme has continued through the year with the completion of the refurbishment of a trauma admissions unit. The newly refurbished ward is bright, calm and offers patients and staff an excellent environment for care and treatment.

### 9.2 New Ward Design for People with Dementia
One of the Trust's wards for older people has been upgraded to make it better able to support people admitted with dementia. Based on research and facilitated by the King's Fund the ward combines layout, colours, pictures and lighting to help patients with cognitive impairment as a result of dementia or other conditions.

### 9.3 Nutrition
The Trust is very conscious of the national reports of the issues around mealtimes for patients and the potential for people to become malnourished. This has seen a number of initiatives during the year to help improve the nutrition of patients in the Trust. The mealtime companion scheme has continued through the year. A new finger food menu has been implemented to help patients manage food and encourage them to eat.

### 9.4 Privacy and Dignity for Older People

To improve the privacy and dignity of older people in the Trust's medicine for the elderly wards the Trust has completed an upgrade programme that has reduced the number of beds in each bay and created an en-suite facility in each bay. Patients can now use toilet and washing facilities in their bay without the need to venture across the ward's main corridor. The en suites are suitable for people with limited mobility and are readily accessible.

### 9.5 Patient Discharge

The improvement in the delays to patients getting out of hospital has been noted earlier in this report. There have also been improvements to the quality and safety of patients discharge. Foremost amongst this has been the ground breaking assisted discharge scheme where the Trust has worked in partnership with the Red Cross. Vulnerable people are now accompanied home with someone there to make sure they are safe and provided for at home.

### 9.6 Trust and Individual Staff Recognition

During 2012-2013 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.

### 9.7 Keeping Patients and Staff Safe

The Trust is assessed by its insurers, the National Health Service Litigation Authority, against their risk management standards. The Trust has maintained a Level 3 assessment mark throughout 2012-2013. This is the highest assessment level.

### 9.8 Golden Rules

At Poole Hospital we are justly proud of the service we provide but there is always room for improvement. The Golden rules and associated 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. Report after report (Care Quality Commission, Ombudsman's report, Francis enquiry) has shown that the NHS is not always giving patients and their families the care and support they deserve. The Golden Rules 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.

### 9.9 Improvements Cancer Care

The standard of cancer care has been rated amongst the best in the country but the Trust is determined to improve services further. With the help of the Poole Hospital Cancer Treatment Trust and other donors the Trust has installed and commissioned a new 3T MRI scanner providing the most detailed and powerful of scans available enabling clinical staff to identify and manage cancer much better.

### 9.10 Patient Choice

The Trust commissioned and opened a new suite for private patients in October 2012. This suite gives patients the choice of having private care in their local NHS hospital whilst at the same time the Trust is able to generate income that can be ploughed back into the NHS.

# 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 2013 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.

Members of the Board and on a regular basis the Quality, Safety and Performance Committee have undertaken visits to clinical and non-clinical areas of the Trust to see and hear at firsthand what patients and the public experience.

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.

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.

A public consultation on the proposed merger of Poole Hospital NHS Foundation Trust with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust closed on 25th April 2012. The results of the consultation have been published and the work on merger has continued. As part of their consideration of the proposed merger the Competition Commission undertook a patient survey in the outpatient departments of Poole Hospital and the outcome of this survey has been published.

# 11. Statements from external bodies

This Quality Report was sent to:

- Dorset Clinical Commissioning Group (Lead Commissioner)
- Borough of Poole, Overview and Scrutiny Committee
- Borough of Bournemouth, Overview and Scrutiny Committee
- Dorset County Council, Overview and Scrutiny Committee
- Health watch Dorset (replaced the Poole Local Involvement Network (LINk) from 1st April 2012)
- Council of Governors of Poole Hospital NHS Foundation Trust (members of Quality Report Task Group)

The following comments have been made:

## 11.1 Dorset Clinical Commissioning Group

In 2012/13 Poole Hospital NHS Foundation Trust has pursued achievement of the key quality priorities identified in the 2011/12 quality account. Over the year the Trust has shown some improvement in relation to readmissions, delayed discharges and post-surgical infection. The report details the challenges in meeting improvement priorities in relation to Accident and Emergency waiting times and placing patients in the right place at the right time. It also acknowledges the challenges in achieving appropriate training levels in children's safeguarding across the Trust. The CCG supports the commitment the Trust gives to continue to work towards improvements in these areas. The CCG has not been actively engaged in the development of the Quality Improvement Priorities that the Trust has set for 2013/4 but is in broad support of these priorities and looks forward to working with Poole Hospital NHS Foundation Trust over the coming year.

## 11.2 Borough of Poole, Overview and Scrutiny Committee

Health and Social Care Overview and Scrutiny Committee response to Poole Hospital NHS Foundation Trust's Quality Account 2012/13

Members of Borough of Poole's Health and Social Care Overview and Scrutiny Committee would like to thank Poole Hospital NHS Foundation Trust for the opportunity to comment on the impressive and comprehensive account of the achievements and areas for improvement detailed in the draft Quality Report for 2012/13. Helping us understand how Poole Hospital is meeting our citizen's expectations for high quality healthcare.

The HSCOSC are impressed to learn of the Trust's achievements against quality standards despite the "distractions" faced in discussing proposals for the merger with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

Members are especially pleased regarding the very positive endorsements from patients who have rated Poole Hospital as the best acute Hospital in Dorset as well as judging that in their opinion the Trust's performance had improved still further on the previous year's good performance. We are also pleased to note that the standard of cancer care is amongst the best in the country and the Trust is determined to improve services even further.

We commend the Trust in fully achieving what it had planned in terms of improving

performance around 3 of its key quality improvement measures: readmissions, delayed discharges and infection prevention. We note the Trust's acknowledgement of the role played by LINks, NHS Commissioners, the Local Authorities, patient groups and the Red Cross in helping to contribute to safer and earlier patient discharges. We also note improvements in terms of preventing falls and infections and in particular managing patients presenting with the norovirus.

We are, however, concerned that 2 of the 5 quality improvement measures (increasing the right patient in the right place at the right time and increasing the percentage of people seen and treated within 4 hours in the Emergency Department) were not achieved due to the pressure on hospital admissions throughout the winter. We note that these form 2 of your 5 improvement priorities for 2013/14 and would ask for an early report on progress to be presented to members in the next year.

We would also appreciate an update on your plans to improve A&E discharges /transfers as well as improving the time taken to deal with broken bones. We are pleased to note the hospital met the 18 week target for referral to admission and are confident that this good performance will continue throughout 2013/14.

In terms of patient-centred care as well as dignity and respect we note the positive results of the Trust's encouragement to staff to reflect on and improve services as well as use what is known as the "Poole Approach;"(AD MOREM VILLAE DE POOLE!) it is good to see that this approach has resulted in the Trust being one of only six hospitals nationally to achieve such high ratings in the Care Quality Commission's recent national patient survey. We would also support the hospital's approach in endorsing a culture where staff is encouraged to report incidents posing a risk to patient safety so that lessons are learned.

Members are pleased to note that the views patients, the public and staff as well as the Council of Governors have been used to inform the improvement targets for 2013/14. We look forward to receiving details of progress regarding the care of people with dementia, maximizing the use of day theatres and the assessment of patients for venous thrombo embolisms on admission in next year's Quality Report. We also commend the Trust on its commitment to develop/ improve patient information, improve the education/ training of new and existing staff, update local clinical working practices and carry out further work to develop policy/guidance documents.

Finally, it is good to note that a re-inspection by the Care Quality Commission in December 2012 found that the Trust had put in place a detailed action plan which rectified an issue raised at a CQC inspection in July 2012.

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

No comments received

### 11.4 Dorset County Council Health Scrutiny Committee

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 again 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.

A Task and Finish Group, drawn from the Committee, has worked with both of these trusts throughout the year in order to have a dialogue with them as they develop their Quality Accounts. This approach has also given members the opportunity to gain a fuller understanding of some of the issues around quality and helped in formulating their response to the Accounts.

### 11.5 Healthwatch Dorset

No comments received

### 11.6 Council of Governors

"Having read the Report I am filled with admiration (once again!) for all the work that goes on at the Hospital. It is truly an impressive document, I do not know how staff keep up with all the demands placed upon them, and how you find the time to produce such a detailed report even allowing for the fact that you are assisted by having computer records to assist you."

"I have read the report and I think that everything that I would like to see is there. I think that it makes clear that in some respects that business is thankfully very much as usual."

# ANNEX 1 to QUALITY REPORT 2012-2013

## 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 2012-13;

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 2012 to April 2013
- Papers relating to Quality reported to the Board/Board sub-committee over the period April 2012 to April 2013
- Feedback from the commissioners dated 21/05/2013
- Feedback from governors dated 27/05/2012
- Feedback from Healthwatch dated (no comments received)
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25/07/2012.
- The 2012 national patient survey April 2013
- The 2012 national staff survey February 2013
- The Head of Internal Audit's annual opinion over the trust's control environment dated 19/04/2013
- CQC quality and risk profiles dated; 10/04/2012, 06/06/2012, 05/07/2012, 07/08/2012, 05/10/2012, 06/11/2012, 05/12/2012, 06/02/2013, 06/03/2013.

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

29 May 2013 Angela Schofield, chairman

29 May 2013 Chris Bown, chief executive

# ANNEX 2 to QUALITY REPORT 2012-2013

## Independent Auditor's 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 for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

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 2013, 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.

### Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor are as follows:

- C Difficile; and
- 62 day cancer wait times from urgent referral until treatment.

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

### Respective responsibilities of the Directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. 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.

## Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Analytical procedures.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

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

## Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual. The scope of our assurance work has not included governance over quality or non-mandated indicators 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, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP
Chartered Accountants
Reading
29th May 2013

# Financial report

Despite the financial challenges facing the sector the trust has achieved its key financial objectives:

- Achieved an operating surplus of £1.3m before the impact of the revaluation of the estate
- Increased income from £195.7m in 2012/13 to £202.4m in the current year
- Maintained a healthy liquidity position with cash balances of £15m at the end of the year (last year £15.3m)
- Invested £11.8m in the hospital and its equipment
- Maintained a Monitor Financial Risk Rating of 3

However the trust continues to face significant financial challenges, in common with the rest of the NHS, as a result of the significant changes facing the commissioning and provision of health services. Over the next three years the trust will be required to improve financial performance by 4% to 5% per year, equivalent to approximately £10m each year. The Trust's ability to deliver this level of financial improvement as an independent Trust is restricted by the fact that the organisation:

- Is already a relatively low cost provider with a reference cost index of 93 compared to a national average of 100
- Has already reduced corporate service costs to the absolute minimum and has outsourced or shared all possible corporate services including financial, payroll, procurement, informatics, estates, occupational health and domestic services
- Will reduce costs further during 2013/14 but despite extensive work, including independent assessment, will be unable to identify further significant opportunities to reduce bed numbers or staffing costs
- Is primarily a provider of emergency services which are poorly remunerated and offer limited opportunities for profitable growth
- Faces increased competition or lower prices or both through the commissioners' plans to tender certain services to 'Any qualified Provider'. Current plans include dermatology, endoscopy and pain services

As a result the Board of Directors has decided that the Trust will not deliver the level of savings required beyond 2013/14 without a fundamental change in the way services are configured and provided. It is therefore the Board's intention to progress merger with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust as soon as possible.

## Charitable income

Total charitable income received during the period amounted to £987k and £2,548k was spent.

The balance of funds held at 31 March 2013 totalled £2,714k. 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 2013 £000** | Year to 31 March 2012 £000 |
|---|---|---|
| Management costs | **7,687** | 7,451 |
| Income | **202,421** | 195,052 |
| **Management costs as a percentage of income** | **3.8%** | 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

## Public Sector Payment Policy

Better Payment Practice Code

| | Year to 31 March 2013 | |
|---|---|---|
| | Volume | Value |
| Percentage of bills paid within target | 66% | 64% |

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 2013

# Annual governance statement

## 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 2013 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 Group 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:

4.2.1Trust 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 Corporate 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, Safety and Performance 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 Corporate 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, Bournemouth and Poole, Service Level Agreements with other organisations and The Trust's Annual Plan;

4.3.2 the trust identified 17 strategic risks at the start of the year and resolved one in year with another ten at the end of the year. Two risks are improving but unresolved (acute surgical services and engagement with staff) and four remain as unresolved (merger, reputational risk, bed occupancy and targets)

4.3.3 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;

4.3.4 key controls & systems are identified and systems and processes are listed that currently help control the risks identified;

4.3.5 the Assurance Framework has been linked to the relevant entries to the Trust Risk Register and 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 Meeting all national targets: - The Trust has dealt with gaps in endoscopy waiting and with the help of partner agencies reduced delayed discharges.

4.4.2 At the end of year it also identified a gap in the assurance around the information governance toolkit where the Trust was non-compliant with a score of 60% in reporting to the Information Commissioner

And an unresolved strategic risk:

4.4.3 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 but faces a severe financial challenge in future years should merger not progress.

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.

## 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 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.

7.5 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, ensure continuous improvement of the system and maintain focus on Trust performance are in place.

7.6 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, has not identified any significant internal control issues at this time.

Signed

Mr Chris Bown
Chief Executive

Date: 29 May 2013

**INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF POOLE HOSPITAL NHS FOUNDATION TRUST**

We have audited the financial statements of Poole Hospital NHS Foundation Trust for the year ended 31 March 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and the related notes 1 to 26. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Poole Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

**Respective responsibilities of the accounting officer and auditor**
As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

**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 trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

**Opinion on financial statements**
In our opinion the financial statements:

- give a true and fair view of the state of the trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

**Opinion on other matters prescribed by the National Health Service Act 2006**
In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; 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**
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, 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;
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

**Susan Barratt**, BA ACA (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Southampton, UK
29 May 2013

# ANNUAL REPORT & ACCOUNTS 2012/13



# Annual accounts 2012/13

## Foreword to the accounts

Poole Hospital NHS Foundation Trust

These accounts for the year ended 31 March 2013 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: 29 May 2013

**Statement of Accounting Officer's responsibilities**

**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).

Signed Chief Executive and Accounting Officer

Name: Christopher Bown

Date: 29 May 2013

## STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2013

| | NOTE | 2012/13 £000 | 2011/12 £000 |
|---|---|---|---|
| **Operating income** | 2 | **202,421** | 195,686 |
| **Operating expenses** | 3 | **(208,078)** | (192,737) |
| **OPERATING (DEFICIT)/SURPLUS** | | **(5,657)** | **2,949** |
| **Finance Costs** | | | |
| Finance income | 5 | **119** | 145 |
| Finance costs - financial liabilities | 6 | **(22)** | (36) |
| Finance costs - interest expense - unwinding of discount | 16 | **(14)** | (14) |
| Public Dividend Capital dividends payable | | **(2,870)** | (2,928) |
| **Net Finance Costs** | | **(2,787)** | (2,833) |
| **(DEFICIT)/SURPLUS FOR THE YEAR (See Note a below)** | | **(8,444)** | **116** |
| **Other comprehensive (expense)/income** | | | |
| Impairments/Revaluations | | **9,043** | 1,093 |
| Other recognised gains and losses | | **0** | 0 |
| **TOTAL COMPREHENSIVE (EXPENSE)/INCOME FOR THE YEAR** | | **599** | **1,209** |

Note a : The Deficit for the year amounting to £8,444k includes impairment of £9,732k in respect of property, plant and equipment following the revaluation of the estate by the District Valuer as at 31 March 2013.

The following notes 1 to 26 form part of these accounts.

All income and expenditure is derived from continuing operations.

## STATEMENT OF FINANCIAL POSITION AS AT 31 March 2013

| | NOTE | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|---|
| **NON CURRENT ASSETS** | | | |
| Intangible assets | 7 | **1,492** | 596 |
| Property, plant and equipment | 8 | **102,589** | 101,520 |
| Trade and other receivables | 11 | **991** | 979 |
| | | **105,072** | 103,095 |
| **CURRENT ASSETS** | | | |
| Inventories | 10 | **1,806** | 1,931 |
| Trade and other receivables | 11 | **6,510** | 6,938 |
| Cash and cash equivalents | 17 | **15,000** | 15,358 |
| **TOTAL CURRENT ASSETS** | | **23,316** | 24,227 |
| **CURRENT LIABILITIES** | | | |
| Trade and other payables | 12.1 | **(22,072)** | (21,105) |
| Borrowings | 13 | **(200)** | (316) |
| Provisions | 16 | **(667)** | (999) |
| **TOTAL CURRENT LIABILITIES** | | **(22,939)** | (22,420) |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | | **105,449** | 104,902 |
| **NON CURRENT LIABILITIES** | | | |
| Borrowings | 13 | **(91)** | (223) |
| Provisions | 16 | **(564)** | (524) |
| **TOTAL NON CURRENT LIABILITIES** | | **(655)** | (747) |
| **TOTAL ASSETS EMPLOYED** | | **104,794** | 104,155 |

**FINANCED BY:**

| | | |
|---|---|---|
| **TAXPAYERS' EQUITY** | | |
| Public dividend capital | **87,651** | 87,611 |
| Revaluation reserve | **17,645** | 9,330 |
| Income and expenditure reserve | **(502)** | 7,214 |
| **TOTAL TAXPAYERS' EQUITY** | **104,794** | 104,155 |

The financial statements were approved by the Board on 29 May 2013 and signed on its behalf by:

**Signed:** **Date:**
**Chief Executive** **29 May 2013**

**Name: Christopher Bown**

**Signed:**
**Director of Finance** **Date:**
**29 May 2013**

**Name: Paul D Turner**

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

| | Public dividend capital (PDC) | Revaluation reserve | Income and Expenditure Reserve | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Balance at 31 March 2012** | **87,611** | **9,330** | **7,214** | **104,155** |
| **Changes in taxpayers' equity for 2012/13** | | | | |
| Total Comprehensive Income for the year: | | | | |
| Retained surplus/(deficit) for the year | 0 | 0 | (8,444) | (8,444) |
| Impairments/Revaluations charged to the Revaluation Reserve (refer to Notes 8.1 and 8.2) | 0 | 9,043 | 0 | 9,043 |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve | 0 | (728) | 728 | 0 |
| Public Dividend Capital received | 40 | 0 | 0 | 40 |
| **Balance at 31 March 2013** | **87,651** | **17,645** | **(502)** | **104,794** |
| **Balance at 1 April 2011** | **86,049** | **10,005** | **5,330** | **101,384** |
| **Changes in taxpayers' equity for 2011/12** | | | | |
| Total Comprehensive Income for the year: | | | | |
| Retained surplus for the year | 0 | 0 | 116 | 116 |
| Impairments/Revaluations charged to the Revaluation Reserve (refer to Notes 8.3 and 8.4) | 0 | 1,093 | 0 | 1,093 |
| Other transfers between reserves | 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 |
| Other recognised gains and losses | 0 | (1,768) | 1,768 | 0 |
| Public Dividend Capital received | 1,562 | 0 | 0 | 1,562 |
| **Balance at 31 March 2012** | **87,611** | **9,330** | **7,214** | **104,155** |

## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2013

| | 2012/13 £000 | 2011/12 £000 |
|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | |
| **Operating (deficit)/surplus from continuing operations** | **(5,657)** | **2,949** |
| **Non-cash income and expense:** | | |
| Depreciation and amortisation | 9,193 | 8,859 |
| Impairments | 9,732 | 839 |
| Loss on Disposal | 0 | 218 |
| Decrease/(increase) in trade and other receivables | 434 | (1,319) |
| Decrease in inventories | 125 | 121 |
| Increase in trade and other payables | 967 | 2,324 |
| (Decrease) in other liabilities | 0 | (271) |
| (Decrease)/increase in provisions | (292) | 917 |
| Other movements in operating cash flows | (13) | (29) |
| **Net cash generated from operations** | **14,489** | 14,608 |
| **Cash flows from investing activities** | | |
| Interest received | 119 | 145 |
| Purchase of property, plant and equipment | (10,736) | (6,486) |
| Purchase of intangible assets | (1,111) | (197) |
| Sales of property, plant and equipment | 0 | 0 |
| **Net cash generated generated used in investing activities** | **(11,728)** | (6,538) |
| **Cash Flows from financing activities** | | |
| Public dividend capital received | 40 | 1,562 |
| Capital element of finance lease rental payments | (249) | (293) |
| Interest element of finance lease | (22) | (36) |
| PDC Dividend paid | (2,888) | (2,914) |
| Cash flows from other financing activities | 0 | 0 |
| **Net cash used in financing activities** | **(3,119)** | (1,681) |
| **(Decrease)/Increase in cash and cash equivalents** | **(358)** | 6,389 |
| **Cash and Cash equivalents at 1 April** | **15,358** | 8,969 |
| **Cash and Cash equivalents at 31 March** | **15,000** | 15,358 |

# 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 2012/13 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. 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. Other income includes funding from the NHS South of England in respect of training and education for training posts (primarily junior doctors) and also recharges of clinical staff to local foundation trusts.

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.

***Pension costs continued***

*NHS Pension Scheme*

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 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 provides 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 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.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

**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, 31 January 2012 and 31 March 2013. See also Note 1.21 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 |

**1.4 Property, Plant and Equipment Cont'd**

**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 valueless 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.

**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.

### 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 which 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 on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

***Leases of land and buildings***

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

**1.10 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 the discount rates published and mandated by HM Treasury.

***Clinical negligence costs***

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 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 are 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 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.

**1.20 Accounting Standards issued but not adopted**

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but have not yet been adopted in the Annual Reporting Manual. Monitor does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period.

IAS 27 Separate Financial Statements
IAS 28 Associates and Joint Ventures
IFRS 9 Financial Instruments
IFRS 10 Consolidated Financial Statements
IFRS 11 Joint Arrangements
IFRS 12 Disclosure of Interests in Other Entities
IFRS 13 Fair Value Measurement
IPSAS 32 Service Concession Arrangements

The directors do not expect that the adoption of these standards and interpretations will have a material impact on the financial statements in future periods. All other revised and new standards have not been listed here as they are not considered to have an impact on the Foundation Trust.

**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 March 2013 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 the discount rates published and mandated by HM Treasury. Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.35% in real terms.

In the view of the Trust there are no further estimates or judgements which if wrong could materially affect financial performance. Final contract sums have been agreed with all Commissioners in respect of activity undertaken during 2012/13. This income is included in the Accounts.

## 2 OPERATING INCOME

### 2.1 Operating Income

| **Income from Activities** | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| Elective income | **26,353** | 26,303 |
| Non elective income | **69,639** | 71,793 |
| Outpatient income | **23,886** | 24,814 |
| A & E income | **5,824** | 5,227 |
| Other NHS Clinical Income | **51,565** | 47,770 |
| Private patient income | **1,833** | 1,514 |
| Other types of activity income | **1,245** | 1,520 |
| | **180,345** | 178,941 |

| **Other Operating Income** | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| Education and training | **5,599** | 5,859 |
| Charitable and other contributions to expenditure (Note 1) | **2,524** | 301 |
| Non-patient care services to other bodies | **7,443** | 4,784 |
| Reversal of impairment property, plant and equipment | **0** | 634 |
| NHS income for staff costs accounted on a gross basis | **2,469** | 1,422 |
| Research income | **352** | 380 |
| Income generation (Note 2) | **1,747** | 1,709 |
| Other income | **1,942** | 1,656 |
| | **22,076** | 16,745 |
| **Total Operating Income** | **202,421** | 195,686 |

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. Income generation relates mainly to restaurant income and car park income received by the Trust

### 2.2 Private Patient Income

| | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| Private patient income | **1,833** | 1,514 |
| Total patient related income | **180,345** | 178,941 |
| **Actual % of Total Income** | **1.0%** | 0.8% |

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

| | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| Mandatory | **177,267** | 175,907 |
| Non-Mandatory | **3,078** | 3,034 |
| **Actual** | **180,345** | 178,941 |

**2.4 Income from Activities by Source**

| | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| Primary Care Trusts | **177,220** | 175,035 |
| Local Authorities (see Note 1) | **122** | 127 |
| NHS Other | **140** | 1,009 |
| Non NHS: Private patients | **1,833** | 1,514 |
| Non-NHS: Overseas patients (non-reciprocal) | **9** | 22 |
| NHS injury scheme (see Note 2) | **956** | 1,014 |
| Non NHS: Other | **65** | 220 |
| | **180,345** | 178,941 |

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 12.6% (2011/12 10.5%) to reflect expected rates of collection.

## 3 Operating Expenses and Operating Lease Costs

### 3.1 Operating Expenses (by type):

| | 2012/13 | 2011/12 |
|---|---|---|
| | £000 | £000 |
| Services from other Foundation Trusts | **3,461** | 1,838 |
| Services from NHS trusts | **64** | 234 |
| Services from other NHS bodies | **237** | 218 |
| Purchase of healthcare from non NHS bodies | **90** | 32 |
| Employee Expenses - Executive Directors' costs (Note 4) | **902** | 959 |
| Employee Expenses - Non Executive Directors' costs (Note 4) | **134** | 131 |
| Employee Expenses - Staff (Note 4 and Note b below) | **131,637** | 125,778 |
| Redundancy (net charge after provisions) | **177** | 1,072 |
| Supplies and services - clinical drugs | **16,449** | 17,669 |
| Supplies and services - clinical other | **14,219** | 13,346 |
| Supplies and services - general | **4,845** | 4,670 |
| Establishment | **1,855** | 2,133 |
| Transport | **1,067** | 821 |
| Premises | **5,588** | 5,048 |
| Bad debts | **71** | 130 |
| Depreciation and amortisation | **9,193** | 8,859 |
| Impairment of property, plant and equipment | **9,732** | 1,473 |
| Audit fees - statutory audit (see Note a) | **95** | 88 |
| Audit fees - prior year audit fees (see Note a) | **0** | 19 |
| Consultancy Costs | **677** | 977 |
| Clinical negligence Insurance Costs | **5,207** | 4,954 |
| Other Services including External Payroll | **744** | 550 |
| Training and course fees etc. | **430** | 424 |
| Legal Fees | **432** | 251 |
| Loss on Disposal of Other Property, plant and Equipment | **0** | 218 |
| Other (Note a) | **772** | 845 |
| | **208,078** | 192,737 |

Note a. The Council of Governors has appointed Deloitte LLP as external auditors of the Trust with effect from 1 October 2012. The audit fee for the year represents 50% of the agreed annual fee with Deloitte and 50% of the agreed annual fee with PriceWaterhouseCooper LLP for the statutory audit on the annual accounts and quality report.

The professional fees (excluding Vat) earned by Deloitte in the 2012/13 Audit of the Trust are as follows:

| | 2012/13 |
|---|---|
| | £000 |
| Financial Statement audit | **43** |
| Whole of Government Accounts | **3** |
| Quality Accounts work | **13** |
| **Total Audit Fee** | **59** |

Note b. Included within staff cost is £988k in relation to research and development spend in 2012/13.

### 3.2 Arrangements containing an operating lease

| | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| Minimum lease payments | **138** | 139 |
| | **138** | 139 |

| | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| **Future minimum lease payments due (see Note):** | | |
| Not later than one year | **138** | 139 |
| Later than one year and not later than five years | **552** | 556 |
| Later than five years | **382** | 554 |
| | **1,072** | 1,249 |

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 years ending 31st March 2013 and 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 2012/13 as follows: Bournemouth & Poole, and Dorset PCTs, representing 56% (2011/12 61%) and 28% (2011/12 23%) of its total income respectively.

**Summary of Key Financial Information**

| | Year to 31 March 2013 | | | Year to 31 March 2012 | | |
|---|---|---|---|---|---|---|
| | Actual | Original Plan | Variance | Actual | Original Plan | Variance |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Income** | 202,421 | 193,891 | 8,530 | 195,052 | 188,116 | 6,936 |
| **Operating Expenditure** | 189,153 | 179,883 | (9,270) | 182,187 | 176,844 | 5,343 |
| **EBITDA** | 10,744 | 11,195 | (451) | 12,647 | 11,272 | 1,375 |
| **EBITDA %** | 6.50% | 6.00% | (0.50%) | 6.50% | 6.00% | 0.50% |
| **(Deficit)/Surplus before impairment** | **1,288** | **2,100** | **812** | **955** | **157** | 798 |
| **Impairment** | (9,732) | 0 | (9,732) | (839) | - | (839) |
| **Surplus after impairment** | (8,444) | 2,100 | (10,544) | 116 | 157 | (41) |
| **Cost Improvement Savings** | 3,331 | 5,737 | (2,406) | | | |
| **Cost Improvement Savings (Incl. income)** | 8,391 | 8,847 | (456) | 9,749 | 11,181 | (1,432) |
| **Cash Balance** | 15,000 | 13,415 | 1,585 | 15,358 | 8,971 | 6,387 |
| **Capital Expenditure** | 11,848 | 11,584 | (264) | 7,710 | 6,983 | 727 |
| **FRR (Financial Risk Rating)** | 3 | 3 | - | 3 | 3 | - |

## 4 Employee costs and numbers

### 4.1 Employee Expenses

| | **2012/13 Total** | 2011/12 Total |
|---|---|---|
| | **£000** | £000 |
| Salaries and wages | **108,436** | 104,875 |
| Social Security Costs | **8,468** | 8,162 |
| Employer contributions to NHS Pension Scheme | **12,835** | 12,641 |
| Termination Payments | **177** | 1,072 |
| Agency/Contract Staff | **2,800** | 1,059 |
| | **132,716** | 127,809 |

### 4.2 Average Number of Employees

| | **2012/13 Total** | 2011/12 Total |
|---|---|---|
| | **Number** | Number |
| Medical and dental | **362** | 368 |
| Administration and estates | **573** | 585 |
| Healthcare assistants and other support staff | **161** | 160 |
| Nursing, midwifery and health visiting staff | **1,215** | 1,196 |
| Scientific, therapeutic and technical staff | **275** | 266 |
| Bank and Agency Staff (see Note) | **206** | 155 |
| Other | **316** | 318 |
| Total | **3,108** | 3,048 |

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 2012/13 there were two (2011/12 five) early retirements on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £52k (2011/12 £526k). 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 Employee costs and numbers - continued

### 4.5 Staff Exit Packages

| | | | | | | | 2011/12 | |
|---|---|---|---|---|---|---|---|---|
| | **Number of Compulsory Redundancies** | **Cost of Compulsory Redundancies** | **Number of Other Departures Agreed** | **Cost of Other Departures Agreed** | **Total Number of Exit Packages** | **Total Cost of Exit Packages** | Total Number | Total Cost |
| **Exit package cost band** | | **£000** | | **£000** | | **£000** | | £000 |
| Less than £10,000 | 2 | 13 | | | **2** | **13** | 7 | 36 |
| Between £10,000 and £25,000 | | | 1 | 19 | **1** | **19** | 2 | 39 |
| Between £25,001 and £50,000 | | | 1 | 43 | **1** | **43** | 4 | 130 |
| Between £50,001 and £100,000 | 4 | 227 | | | **4** | **227** | 2 | 142 |
| Between £150,001 and £200,000 | 1 | 152 | | | **1** | **152** | | |
| **Total** | **7** | **392** | **2** | **62** | **9** | **454** | 15 | 347 |

### 4.6 Remuneration of Directors

| | **Total** | **Benefits in Kind** | **2012/13 Employer's Pension Contributions** | **Employer's National Insurance** | **Remuneration** |
|---|---|---|---|---|---|
| | **£000** | **£000** | **£000** | **£000** | **£000** |
| Executive Directors | **901** | 0 | 89 | 87 | 725 |
| Non -Executive Directors | **134** | 0 | 0 | 10 | 124 |
| **Total** | **1,035** | **0** | **89** | **97** | **849** |

| | **Total** | **Benefits in Kind** | **2011/12 Employer's Pension Contributions** | **Employer's National Insurance** | **Remuneration** |
|---|---|---|---|---|---|
| | **£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** |

Note: The detail of the Directors' remuneration has been disclosed in the 2012/13 remuneration report within the Annual Report of the Foundation Trust. The above sums reflect actual payments made in the year

## 5 Finance Income

| | 2012/13 £000 | 2011/12 £000 |
|---|---|---|
| Interest on Loans and Receivables | **119** | 145 |
| | **119** | 145 |

## 6 Finance Costs - Interest Expense

| | 2012/13 £000 | 2011/12 £000 |
|---|---|---|
| Finance Leases | **22** | 36 |
| | **22** | 36 |

## 7 Intangible Assets

| | 2012/13 | |
|---|---|---|
| | **Software licences** | **Total** |
| | **£000** | **£000** |
| Gross cost at 1 April 2012 | 810 | 810 |
| Additions - Purchased | 660 | 660 |
| Additions - Donated | 451 | 451 |
| **Gross cost at 31 March 2013** | **1,921** | **1,921** |
| Amortisation at 1 April 2012 | 214 | 214 |
| Charged during the year | 215 | 215 |
| **Amortisation at 31 March 2013** | **429** | **429** |
| **Net book value** | | |
| - Purchased at 1 April 2012 | 545 | 545 |
| - Donated at 1 April 2012 | 51 | 51 |
| **- Total at 1 April 2012** | **596** | **596** |
| - Purchased at 31 March 2013 | 1,011 | 1,011 |
| - Donated at 31 March 2013 | 481 | 481 |
| **- Total at 31 March 2013** | **1,492** | **1,492** |

**8.1 Property, Plant and Equipment 2012/13**

**Tangible fixed assets at the Statement of Financial Position date comprise the following elements:**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction & payments on account | Plant and machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Cost or valuation at 1 April 2012 | 11,875 | 70,055 | 1,425 | 1,769 | 34,866 | 28 | 9,077 | 467 | 129,562 |
| Additions purchased | 0 | 4,312 | 9 | 420 | 2,132 | 0 | 1,851 | 11 | 8,735 |
| Additions donated | 0 | 191 | 0 | 0 | 1,763 | 0 | 47 | 0 | 2,001 |
| Impairments | (3,350) | (9,421) | 0 | 0 | 0 | 0 | 0 | 0 | (12,771) |
| Reversal of Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | (1,250) | 1,250 | 0 | 0 | 0 | 0 |
| Revaluations | 18 | 8,148 | 135 | 0 | 0 | 0 | 0 | 0 | 8,301 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Cost or Valuation at 31 March 2013** | **8,543** | **73,285** | **1,569** | **939** | **40,011** | **28** | **10,975** | **478** | **135,828** |
| **Depreciation at 1 April 2012** | **0** | **19** | **0** | **0** | **21,751** | **26** | **5,864** | **382** | **28,042** |
| Charged during the year | 0 | 3,713 | 148 | 0 | 3,685 | 1 | 1,406 | 25 | 8,978 |
| Impairments | 0 | 9,732 | 0 | 0 | 0 | 0 | 0 | 0 | 9,732 |
| Reversal of Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 0 | (13,418) | (95) | 0 | 0 | 0 | 0 | 0 | (13,513) |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Depreciation at 31 March 2013** | **0** | **46** | **53** | **0** | **25,436** | **27** | **7,270** | **407** | **33,239** |
| **Net book value** | | | | | | | | | |
| - 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** |
| - Purchased at 31 March 2013 | 8,543 | 68,086 | 1,516 | 939 | 11,823 | 1 | 3,638 | 71 | 94,617 |
| - Donated at 31 March 2013 | 0 | 5,153 | 0 | 0 | 2,490 | 0 | 67 | 0 | 7,710 |
| - Finance Lease at 31 March 2013 | 0 | 0 | 0 | 0 | 262 | 0 | 0 | 0 | 262 |
| **- Total at 31 March 2013** | **8,543** | **73,239** | **1,516** | **939** | **14,575** | **1** | **3,705** | **71** | **102,589** |

**8.2 Analysis of Property, Plant and Equipment at & This year end**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Net book value** | | | | | | | | | |
| - NBV - Protected assets at 31 March 2013 | 8,543 | 73,239 | 1,516 | 0 | 0 | 0 | 0 | 0 | 83,298 |
| - NBV - Unprotected assets at 31 March 2013 | 0 | 0 | 0 | 939 | 14,575 | 1 | 3,705 | 71 | 19,291 |
| **- Total at 31 March 2013** | **8,543** | **73,239** | **1,516** | **939** | **14,575** | **1** | **3,705** | **71** | **102,589** |

Of the totals at 31 March 2013, £818k related to land valued at open market value and £1,516k related to buildings valued at open market value

**8.3 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** |

**8.4 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.

**8.5 The net book value of Property, Plant and Equipment at 31 March 2013 comprises:**

| | 31 March 2013 | 31 March 2012 |
|---|---|---|
| | £000 | £000 |
| **Freehold** | | |
| Protected | 83,298 | 77,950 |
| Unprotected | 19,291 | 23,570 |
| **TOTAL** | **102,589** | 101,520 |

## 9. Net book value of assets held under finance leases

**Tangible fixed assets at the Statement of Financial Position date held under finance leases:**

| | Plant and machinery | Total |
|---|---|---|
| | £000 | £000 |
| Cost or valuation at 1 April 2012 | 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 | (68) | (68) |
| **Cost or Valuation at 31 March 2013** | **1,892** | **1,892** |
| Depreciation at 1 April 2012 | 1,449 | 1,449 |
| Charged during the year | 249 | 249 |
| Reclassifications | 0 | 0 |
| Revaluation surpluses | 0 | 0 |
| Disposals | (68) | (68) |
| **Depreciation at 31 March 2013** | **1,630** | **1,630** |
| **Net book value** | | |
| - Purchased at 1 April 2012 | 511 | 511 |
| - Donated at 1 April 2012 | 0 | 0 |
| **- Total at 1 April 2012** | **511** | **511** |
| - Purchased at 31 March 2013 | 262 | 262 |
| - Donated at 31 March 2013 | 0 | 0 |
| **- Total at 31 March 2013** | **262** | **262** |

Finance leases relate to medical equipment assets.

**10.1 Inventories**

| | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|
| Materials | 1,806 | 1,931 |
| **TOTAL** | **1,806** | 1,931 |

**11.1 Trade receivables and other receivables**

| | Total 31 March 2013 | Financial assets at 31 March 2013 | Non-financial assets at 31 March 2013 | Total 31 March 2012 | Financial assets at 31 March 2012 | Non-financial assets at 31 March 2012 |
|---|---|---|---|---|---|---|
| **Current** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| NHS Receivables | 3,364 | 3,364 | 0 | 3,771 | 3,771 | 0 |
| Other receivables with related parties | 20 | 20 | 0 | 191 | 191 | 0 |
| Provision for impaired receivables | (292) | (127) | (165) | (304) | (181) | (123) |
| Prepayments | 748 | 0 | 748 | 641 | 0 | 641 |
| Accrued income | 114 | 114 | 0 | 107 | 107 | 0 |
| PDC Receivable | 60 | 0 | 60 | 42 | 0 | 42 |
| Other receivables | 2,496 | 822 | 1,674 | 2,490 | 1,078 | 1,412 |
| **Total Current Trade and Other Receivables** | **6,510** | **4,193** | **2,317** | 6,938 | 4,966 | 1,972 |
| **Non-Current** | | | | | | |
| NHS Receivables | 0 | 0 | 0 | 0 | 0 | 0 |
| Provision for impaired receivables | (143) | 0 | (143) | (115) | 0 | (115) |
| Prepayments | 0 | 0 | 0 | 0 | 0 | 0 |
| Accrued income | 0 | 0 | 0 | 0 | 0 | 0 |
| Other receivables | 1,134 | 0 | 1,134 | 1,094 | 0 | 1,094 |
| **Total Non Current Trade and Other Receivables** | **991** | **0** | **991** | 979 | 0 | 979 |

**11.2 Provision for impaired receivables**

| | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| **At 1 April** | 419 | 375 |
| Increase in provision | 71 | 130 |
| Amounts utilised | (55) | (86) |
| Unused amounts reversed | 0 | 0 |
| **At 31 March** | **435** | 419 |

**11.3 Analysis of receivables by age:**

| **Ageing of impaired receivables:** | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| 0-30 Days | 0 | 0 |
| 30-60 Days | 0 | 0 |
| 60-90 Days | 0 | 0 |
| 90-180 Days | 0 | 0 |
| Over 180 Days | 2,644 | 2,696 |
| **At 31 March** | **2,644** | 2,696 |

| **Ageing of non impaired receivables:** | **2012/13** | 2011/12 |
|---|---|---|
| | **£000** | £000 |
| 0-30 Days | 4,717 | 4,279 |
| 30-60 Days | 128 | 510 |
| 60-90 Days | 148 | 122 |
| 90-180 Days | 194 | 505 |
| Over 180 Days | 202 | 224 |
| **At 31 March** | **5,389** | 5,640 |

## 12 Current and Non-Current Liabilities

### 12.1 Trade and other payables

| | **Total 31 March 2013** | **Financial liabilities at 31 March 2013** | **Non-financial liabilities at 31 March 2013** | Total 31 March 2012 | Financial liabilities at 31 March 2012 | Non-financial liabilities at 31 March 2012 |
|---|---|---|---|---|---|---|
| **Current** | | | | | | |
| | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| Receipts in advance | 389 | 0 | 389 | 378 | 0 | 378 |
| NHS payables | 3,026 | 3,026 | 0 | 3,535 | 3,535 | 0 |
| Amounts due to other related parties | 1,723 | 1,723 | 0 | 1,627 | 1,627 | 0 |
| Trade payables - capital | 2,511 | 2,511 | 0 | 2,043 | 2,043 | 0 |
| Other trade payables | 4,981 | 4,981 | 0 | 4,334 | 4,334 | 0 |
| Taxes payable | 2,771 | 0 | 2,771 | 2,790 | 0 | 2,790 |
| Other payables | 1,880 | 1,880 | 0 | 2,179 | 2,179 | 0 |
| Accruals | 4,791 | 4,791 | 0 | 4,219 | 4,219 | 0 |
| **Total Current Trade and Other Payables** | **22,072** | **18,912** | **3,160** | 21,105 | 17,937 | 3,168 |

**13 Borrowings**

| | **At 31 March 2013** | At 31 March 2012 |
|---|---|---|
| | **£000** | **£000** |
| **Current** | | |
| Obligations under finance leases | 200 | 316 |
| **Total Other Current Liabilities** | **200** | 316 |
| **Non-current** | | |
| Obligations under finance leases | 91 | 223 |
| **Total Other Non- Current Liabilities** | **91** | 223 |

**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 2013** | At 31 March 2012 |
|---|---|---|
| | **£000** | **£000** |
| Long term borrowing limit set by Monitor | 37,900 | 36,600 |
| Working capital facility agreed by Monitor | 13,000 | 13,000 |
| **At 31 March** | **50,900** | 49,600 |

Note: The Trust did not avail of any borrowing or working capital facility (apart from finance lease borrowing) in 2012/13 or 2011/12.

| | **2012/13** | | 2011/12 | |
|---|---|---|---|---|
| | **Approved** | **Actual** | Approved | Actual |
| Minimum dividend cover | **4.6x** | **4.6x** | 4.4x | 4.4x |
| 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 2013** | At 31 March 2012 | **At 31 March 2013** | At 31 March 2012 |
| | **£000** | **£000** | **£000** | **£000** |
| **Gross lease liabilities** | | | | |
| **of which liabilities are due:** | | | | |
| not later than one year; | 209 | 275 | 200 | 268 |
| later than one year and not later than five years; | 93 | 296 | 91 | 271 |
| later than five years; | 0 | 0 | 0 | 0 |
| Finance charges allocated to future periods | (11) | (32) | 0 | 0 |
| **Total Gross Lease Liabilities** | **291** | 539 | **291** | 539 |
| **Net lease liabilities** | | | | |
| not later than one year; | 200 | 316 | 200 | 268 |
| later than one year and not later than five years; | 91 | 223 | 91 | 271 |
| later than five years; | 0 | 0 | 0 | 0 |
| **Total net lease liabilities** | **291** | 539 | **291** | 539 |

Note: Finance Leases relate to pharmacy and medical equipment assets.

## 16 Provisions for Liabilities and Charges

| | Total 31 March 2013 | Total 31 March 2012 |
|---|---|---|
| **Current** | | |
| | **£000** | **£000** |
| Pensions relating to other staff | 35 | 34 |
| Other legal claims | 93 | 555 |
| Redundancy | 539 | 410 |
| Other | 0 | 0 |
| **Total Current Provisions for Liabilities and Charges** | **667** | 999 |
| **Non-current** | | |
| | **£000** | **£000** |
| Pensions relating to other staff | 564 | 524 |
| Other | 0 | 0 |
| **Total Non-current Provisions for Liabilities and Charges** | **564** | 524 |

**Provisions for liabilities and charges**

| | Pensions relating to other staff | Legal claims | Redundancy | Other | 31 March 2013 Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| At 1 April 2012 | 558 | 555 | 410 | 0 | 1,523 |
| Arising during the period | 55 | 70 | 539 | 0 | 664 |
| Utilised during the period | (24) | (46) | (344) | 0 | (414) |
| Reversed unused | (4) | (486) | (66) | 0 | (556) |
| Unwinding of discount | 14 | 0 | 0 | 0 | 14 |
| **At 31 March 2013** | **599** | **93** | **539** | **0** | **1,231** |
| 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** |

**Expected timing of cashflows at 31 March 2013:**

| | Pensions relating to other staff | Legal claims | Redundancy | Other | 31 March 2013 Total |
|---|---|---|---|---|---|
| Not later than one year | 35 | 93 | 539 | 0 | 667 |
| Later than one year and not later than five years | 142 | 0 | 0 | 0 | 142 |
| Later than five years | 422 | 0 | 0 | 0 | 422 |
| **Total** | **599** | **93** | **539** | **0** | **1,231** |

Legal claims relate to employer and third party liability claims against the Trust.

**Clinical Negligence Liabilities:**

£42,247k is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the NHS Trust (31 March 2012 £46,807k).

**Non Clinical Liabilities**

Note: Refer to Note 20 re Contingent Liabilities for Non Clinical claims.

## 17 Cash and Cash Equivalents

| | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|
| **At 1 April** | **15,358** | 8,969 |
| Net change in year | (358) | 6,389 |
| **Balance at 31 March** | **15,000** | 15,358 |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 87 | 114 |
| Cash with the Government Banking Service | 14,913 | 15,244 |
| **Cash and Cash Equivalents as in SoFP and SoCF at 31 March** | **15,000** | 15,358 |

## 18 Contractual Capital Commitments

| | 2012/13 £000 | 2011/12 £000 |
|---|---|---|
| Property, Plant and Equipment | 2,848 | 3,219 |
| **Total at 31 March** | **2,848** | 3,219 |

## 19 Events after the Reporting Period

There were no events after the reporting period having a material effect on the accounts.

## 20 Contingent Liabilities

| | 2012/13 £000 | 2011/12 £000 |
|---|---|---|
| Gross value of contingent liabilities | (24) | (28) |
| Amounts recoverable against contingent liabilities | 0 | 0 |
| **Total Contingent Liabilities** | **(24)** | (28) |

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 16 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 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 PCT's for 2012/13 and would expect to carry out similar services for this level of income.

| | 2012/13 | | 2011/12 | |
|---|---|---|---|---|
| | Income | Expenditure | Income | Expenditure |
| **21.1 Value of Transactions with Other Related Parties** | **£'000** | **£'000** | **£'000** | **£'000** |
| Royal Bournemouth and Christchurch NHS FT | 3,390 | 5,449 | 3,303 | 3,248 |
| Bournemouth and Poole PCT | 113,498 | - | 119,375 | 30 |
| Dorset PCT | 45,588 | 114 | 45,955 | 108 |
| Dorset County Hospital FT | 868 | 263 | 902 | 2,794 |
| Dorset Healthcare FT | 2,113 | 479 | 1,965 | 408 |
| South West SHA | 5,280 | | 5,618 | |
| Bristol PCT | 12,682 | | 4,887 | |
| Hampshire PCT | 4,016 | | 3,685 | |
| University Hospital Bristol FT | 969 | | | |
| NHS Litigation Authority | | 5,207 | | 4,954 |
| Dept. of Health (incl. Prescription Pricing Authority 2011/12) | 499 | 35 | | 1,778 |
| NHS Business Authority ( incl. NHS Supply Chain) | | | | 2,994 |
| Other NHS Bodies | 3,275 | 552 | 3,333 | 1,679 |
| National Blood Authority | | 1,248 | | 1,342 |
| NHS Pension Scheme | | 12,673 | | 12,641 |
| National Insurance Fund | | 8,337 | | 8,883 |
| Other WGA Bodies | 196 | 1,340 | 241 | |
| **Total Value of Transactions with Other Related Parties** | **192,374** | **35,697** | 189,264 | 40,859 |

Note: The Trust paid income tax on behalf of its employees to HMR&C amounting to £16,880k (2011/12 £17,309k) and recovered net Vat amounting to £2,691k (2011/12 £2,112k). These amounts have not been included in the schedule above 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 2013 Receivables £000 | At 31 March 2013 Payables £000 | At 31 March 2012 Receivables £000 | At 31 March 2012 Payables £000 |
|---|---|---|---|---|
| Royal Bournemouth and Christchurch NHS FT | 1,813 | 2,398 | 1,858 | 2,077 |
| Bournemouth and Poole PCT | | | | |
| Dorset County Hospital NHS FT | 25 | 13 | 78 | 330 |
| Dorset Healthcare | 254 | 122 | 637 | 90 |
| Bristol PCT | 583 | | 640 | |
| Dorset PCT | 20 | 58 | 111 | - |
| University Hospital Southampton | 16 | 190 | 4 | 303 |
| NHS Pension Scheme | | 1,723 | | 1,627 |
| NHS Business Authority (incl. NHS Supply Chain 2011/12) | | | | 323 |
| Dept. of Health (incl. Prescription Pricing Authority 2011/12) | 447 | - | | 183 |
| Other NHS Bodies | 266 | 64 | 443 | 229 |
| Charitable Funds | 20 | | 108 | |
| National Insurance Fund | | 1,365 | | 1,352 |
| HMR&C | 366 | 1,406 | 243 | 1,438 |
| Other WGA Bodies | 8 | 181 | 56 | |
| Forest Holme | - | | 27 | |
| **Total Balances with Other Related Parties** | **3,818** | **7,520** | 4,205 | 7,952 |

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

### Staff Residences

£206k (£246k 2011/12) is included within operating expenses in respect of PFI transactions deemed to be off SoFP.

The Trust is committed to make a payment of £108k during the next year in respect of a PFI scheme that is expected to expire in approximately 8 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.

### Nursery

£30k (£30k 2011/12) 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 6 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 - £14,913k (31 March 2012 £15,244) 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 (2011/12: £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 12.6% (2011/12 10.5%) 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 £2,848k (£3,219k at 31 March 2012) - see Note 18 and Finance Lease commitments amounted to £291k (£539k at 31 March 2012) - 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 2013.
There are no material differences between the book value and fair value.

| | Loans and Receivables | |
|---|---|---|
| | **31 March 2013** | 31 March 2012 |
| | **£000** | £000 |
| **Financial assets** | | |
| Cash | **15,000** | 15,358 |
| NHS Receivables | **3,364** | 3,771 |
| Accrued Income | **114** | 107 |
| Other Receivables | **715** | 1,088 |
| **Total** | **19,193** | 20,324 |

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 £2,134k (2011/12 £2,276k).
- Prepayments amounting to £798k (2011/12 £641k).
- PDC receivable amounting to £60k (2011/12 £42k).
- Vat recoverable amounting to £366k (2011/12 £243k).

| | Other Financial Liabilities | |
|---|---|---|
| | **31 March 2013** | 31 March 2012 |
| **Financial liabilities** | | |
| **Trade and Other Payables** | | |
| NHS Payables | **3,026** | 3,535 |
| Accruals | **4,791** | 4,219 |
| Capital Payables | **2,511** | 2,043 |
| Other Payables | **8,584** | 8,140 |
| **Total Trade and Other Payables** | **18,912** | 17,937 |
| **Other Financial Liabilities** | | |
| Finance Lease obligations (Note 1) | **291** | 539 |
| Provisions under contract (Note 2) | **599** | 558 |
| **Total Other Financial Liabilities** | **890** | 1,097 |
| **Total** | **19,802** | 19,034 |

The following are not considered to be financial instruments and therefore have been excluded from the above table:
- Other Tax Payables amounting to £2,771k (2011/12 £2,790k).
- Provisions not under contract amounting to £632k (2011/12 £965k).
- Receipts in Advance amounting to £389k (2011/12 £378k).

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 2.35% (2011/12 2.8%) in real terms.

## 25 Third Party Assets

The Trust held £5k cash at bank and in hand at 31 March 2013 (£3k - at 31 March 2012) 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 237 (258 cases 2011/12) cases of losses and special payments totalling £174k (£182k 2011/12) during the period 1 April 2012 to 31 March 2013.

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