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NHS
Dorset County Hospital
NHS Foundation Trust

Annual Report and Accounts

2017 - 2018

Outstanding care for people in ways which matter to them

Dorset County Hospital NHS Foundation Trust

Annual Report and Accounts 2017/18

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

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Performance Report

Overview of the Trust

Purpose of the Overview

The overview is intended as a short summary to understand the organisation, its purpose, the key risks to the achievement of its objectives, and how it has performed during the year.

Statement from the Chair and Chief Executive

We have faced another extremely busy year at Dorset County Hospital with unprecedented demand on our services and pressure on our resources. Despite these ongoing challenges we have continued to meet key standards around waiting times and quality thanks to the sheer determination and resilience of our staff.

It cannot be overestimated how difficult it is to maintain such high standards in the current climate, but again and again our staff amaze us. It was particularly heartening to meet the emergency access standard at the end of March in the face of high demand and two periods of the worst snow to hit Dorset in years. DCH was in fact one of only three hospitals in the country to meet the standard. We have also made improvements against the 18 week standard – again, this is down to exceptional teamwork throughout the organisation.

There have been further improvements in key quality standards such as end of life care, sepsis, harm free care, pressure ulcers and falls to name just a few. In addition we have maintained an excellent standard of infection prevention with very low levels of hospital acquired infections. The improvements in quality are all the more impressive as they have been achieved alongside tight financial controls. Everyone has remained focussed on making efficiencies and savings and we were pleased to be able to finish the financial year with a surplus and secure additional support. This focus will of course continue as we are well aware the financial pressures will only increase.

We have made major steps forward with implementing our People Strategy during the year. The values are embedded in the Trust as is the new appraisal system. Our staff survey results reflected the good work going on and we are continuing to respond to staff feedback with a wellbeing strategy being developed.

We have developed a comprehensive long-term strategy for the Trust and are making good progress with its implementation, particularly in terms of integrated care where our diabetes team are leading the way with a new model for delivering care. We are also working on plans for improving the hospital estate and using the former school site next to our main campus effectively. We are grateful for the support of our partner organisations and their commitment to working together on providing the best services possible for our population.

We are pleased to have developed a Research and Innovation Strategy which will see our research activity increase, particularly multi-professional research. New developments are key for patients and the colorectal team were chosen to run a pilot of a new procedure to treat low rectal cancers.

We are lucky to have some outstanding teams working at DCH. This year a number of staff were recognised with regional and national awards, which is a reflection of the whole organisation and teamwork for the benefit of our patients. We are immensely proud of our hospital and what our teams have achieved and we would like to take this opportunity to thank our staff and all our supporters for their unfailing commitment and drive.

Mark Addison
Chair

Patricia Miller
Chief Executive

Highlights of the Year

April 2017

We were delighted to introduce new state-of-the-art mattresses for our inpatients as part of our rolling replacement programme. The static foam mattresses were replaced with 'hybrid' mattresses which have dynamic cells to provide alternating pressure therapy, a microclimate layer and a memory foam overlay. As well as providing increased comfort for patients the mattresses form part of a package of pressure relieving aids to treat and prevent conditions such as pressure ulcers.

Our Cygnet Homebirth Team celebrated their second anniversary with a picnic in the park. The team hosted an event in Dorchester's Borough Gardens to coincide with International Day of the Midwife and welcomed parents and babies who have benefitted from their fantastic service. Over the two years the work of the team has seen the numbers of births at home rise from 2% to 9.7%, one of the highest home birth rates in the country.

May 2017

The Friends of Dorset County Hospital opened their new purpose-built shop in the hospital. The hugely valued charity moved to the busy corridor near South Wing Entrance 1 to boost their shop operation.

We were proud to again be named as one of the CHKS Top Hospitals, an accolade awarded to the top performing CHKS client trusts. CHKS is part of Capita Healthcare Decisions and the Top Hospitals award is one of several well recognised awards that are part of the Top Hospitals programme. The award is based on the evaluation of a wide range of key indicators and recognises outstanding performance in areas critical to delivering good patient care.

June 2017

Staff and volunteers received well deserved recognition for their hard work and dedication at the GEM (Going the Extra Mile) and Long Service Awards. The awards are presented annually to people who have made an outstanding contribution to the hospital and to those who have achieved 25 years of NHS service. Colleagues, patients and relatives nominated staff and volunteers for a number of awards to honour those who have gone over and above what is expected of them to make a difference to people's lives.

July 2017

Secretary of State for Health Jeremy Hunt spoke with DCH staff about his focus on patient safety during a visit to Dorset's three acute hospitals. Our clinical teams were proud to share the outcomes of the improvements in safe care they have made by working with partners and patients across the health and care system.

September 2017

A team from DCH was one of 16 teams to undertake the 2017 South West NHS Military Challenge. The event is run by 243 (The Wessex) Field Hospital and held at Okehampton Camp on Dartmoor. Our team did an amazing job taking on physically and mentally challenging tests, including care under fire, close combat training, an endurance march and a stretcher race, true #TeamDCH spirit!

October 2017

Hundreds of visitors had the chance to see behind the scenes of their local hospital at our annual open day. The tour programme included theatres, cardiology and the equipment library. There was also the opportunity to take part in the popular CPR challenge and our practice educators demonstrated their teaching aids. Other attractions included free health checks, the teddy bear clinic and a wide range of displays.

We were pleased to launch a new service to maximise patient safety at night. The Critical Care Outreach Team broadened their remit to offer 24 hour cover throughout the hospital for the new ‘Hospital at Night’ service. During the day the outreach team help to manage patients across the hospital whose conditions are worsening and at night this role is expanded to provide a range of services, including prescribing and assessments alongside their medical colleagues.

November 2017

Consultant anaesthetist Dr Duncan Chambler received national recognition for his research within anaesthesia and intensive care medicine, winning the Early Career Consultant Award at the annual research awards run by the National Institute for Health Research Clinical Research Network and Faculty of Intensive Care Medicine.

December 2017

Staff from our Critical Care Unit asked people to think about the gift of organ donation as they switched on their Christmas tree lights. The hospital’s organ donation team sponsor a tree each year in the South Wing courtyard to highlight the importance of discussing their wishes around organ donation.

We were delighted to announce the arrival of state-of-the-art x-ray equipment purchased to replace an older machine due for decommissioning. The new equipment benefits both patients and staff, featuring auto-positioning as well as motorised movement.

We were honoured to be awarded a Silver Defence Employer Recognition Scheme Award by the Wessex Reserve Forces' and Cadets' Association. DCH was one of only 16 organisations in the South West Region to be given the award in recognition of its continued support of members of the Armed Forces community.

A specialist clinic which supports the mental health needs of mums-to-be celebrated its first birthday. The Perinatal Mental Health Antenatal Clinic enables women who require support to see the right professionals through their pregnancy and then plan postnatal care. The team, which includes a consultant perinatal psychiatrist, obstetrician, mental health practitioners and specialist midwives, works closely with West Dorset PANDAS, a local support group for mums affected by anxiety and depression in pregnancy or after their baby is born.

We were really pleased to be chosen as one of five pilot training sites for an enhanced operating technique for patients with rectal cancer. Transanal Total Mesorectal Excision (TaTME) is a different approach to an existing operation, using a laparoscopic (keyhole) technique, reducing the length of surgery and potentially improving cancer survival rates.

January 2018

The cardiology team were thrilled to launch their newly refurbished cardiac catheter lab. This means the hospital now has two high specification catheter labs and can offer reduced waiting times for patients who need heart tests and treatments such as cardiac catheterisation, angioplasty and pacemaker implants.

DCH joined the #endPJparalysis campaign and launched an initiative to help patients to 'get up, get dressed and be active' while in hospital. Research has shown that by supporting patients to wear clothes during the day rather than nightwear when in hospital they can recover more quickly, find it easier to maintain a normal routine and are able to return home sooner.

February 2018

DCH homebirth midwife Ali Fuszard was awarded the Emma's Diary Mums' Midwife of the Year for the South of England region. The prestigious award is one of the Royal College of Midwives (RCM) Annual Midwifery Awards, recognising the incredible work done by exceptional midwives across the country.

March 2018

DCH was in the top 20% of all acute trusts for providing equal opportunities for career progression as well as recognition and value of staff and support from managers, according to the latest staff survey results. The annual NHS National Staff Survey collects views about what it is like working at DCH and the results are used to review and improve aspects of staff's working lives. DCH was ranked in the top 20% of acute hospitals or above average for over half (17 out of 32) of the key findings.

Lead Inflammatory Bowel Disease Nurse Pearl Avery won a national award for going over and above for her patients and service. Pearl received the Gastrointestinal/IBD Nurse of the Year Award at the 2018 British Journal of Nursing Awards. The annual awards showcase nursing excellence, recognising and celebrating individuals who put patient care at the heart of their role, inspire others and drive the profession. Pearl was nominated for striving to provide the best care possible for her patients and pioneering a new patient management system which has earned national recognition.

An NHS research study looking into the rehabilitation of knee replacement patients across Dorset won a prestigious award thanks to the collaborative work of Dorset County Hospital and Dorset HealthCare.

Research teams from the two organisations were presented with the Outstanding Achievement Award at a ceremony hosted by the National Institute for Health Research Clinical Research Network Wessex. The CORKA trial – COmmunity based Rehabilitation after Knee Arthroplasty – compared hospital based rehabilitation with rehab in patients' own homes and is a national trial led by Oxford University.

ICT apprentice Jay Quick won Weymouth College's Information Technology Specialist Apprentice of the Year Award. Jay was nominated for being such an asset to the team with his aptitude and logical approach to ICT, bringing drive and maturity beyond his years.

About the Trust

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

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

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

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

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

The Trust provides the following services for patients:

- Full Emergency Department services for major and minor accidents and trauma;
- Emergency assessment and treatment services, including critical care (the hospital has trauma unit status);
- Acute and elective (planned) surgery and medical treatments, such as day surgery and endoscopy, outpatient services, services for older people, acute stroke care, cancer services and pharmacy services (not an inclusive list);
- Comprehensive maternity services including a midwife-led birthing service, community midwifery support, antenatal care, postnatal care and home births. We have a Special Care Baby Unit;
- Children's services including, emergency assessment, inpatient and outpatient services;
- Diagnostic services such as fully accredited pathology, liquid based cytology, CT scanning, MRI scanning, ultrasound, cardiac angiography and interventional radiology;
- Renal services to all of Dorset and parts of Somerset;

- A wide range of therapy services, including physiotherapy, occupational therapy and dietetics and
- An integrated service with social services to provide a virtual ward enabling patients to be treated in their own homes.

Our business model is based on the national Payment by Results methodology for managing expenditure within the context of agreed contracts with commissioners. The Trust has to manage its reference costs within the national tariff system to allow us to invest appropriately (staff and infrastructure) in order to provide safe, effective patient care.

The Trust is organised internally as follows: there are two Divisions in the Trust, the Urgent and Integrated Care Division and the Family and Surgical Services Division. Each Division has responsibility for general business: workforce, education, access and flow, space utilisation, and capital and strategic planning. In turn they also have responsibility for governance: safety, clinical effectiveness, safeguarding and patient experience. Each Division is then subdivided into a number of care groups which also hold their own speciality/department meetings.

The Divisions report into the Trust Board Committees on a monthly basis. The Committees and their remits are as follows:

- Finance and Performance Committee provides Finance, Access and Workforce Assurance.
- Quality Committee provides Quality Assurance.
- Risk and Audit Committee has a Corporate Governance responsibility to provide Board Assurance Framework (BAF), corporate risks, internal and external audit assurance.
- Senior Management Team provides Strategic Assurance.

All Sub-Board Committees are assurance committees for performance and standards, rather than performance only committees. Sub-Board Committees have formal minutes.

The Trust has one Trust Board and the Committees provide assurance to the Board.

Strategy and Objectives

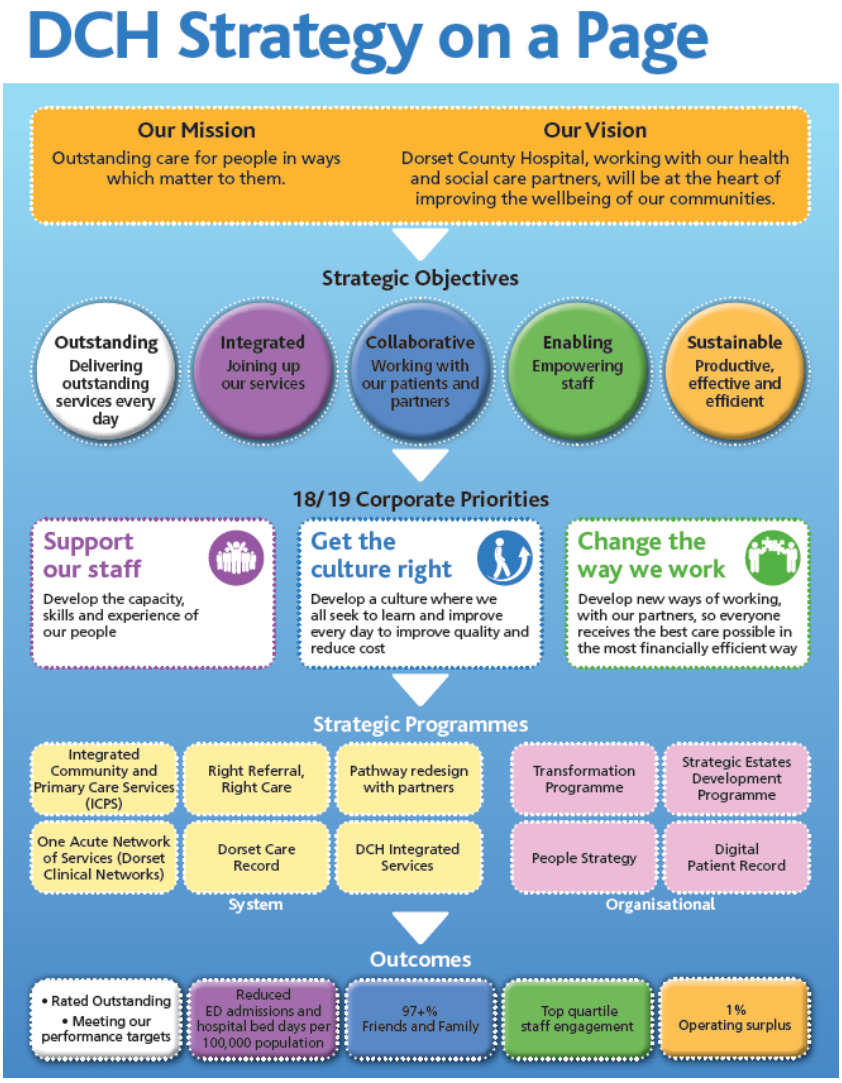
2018 – 2022 Strategic Direction

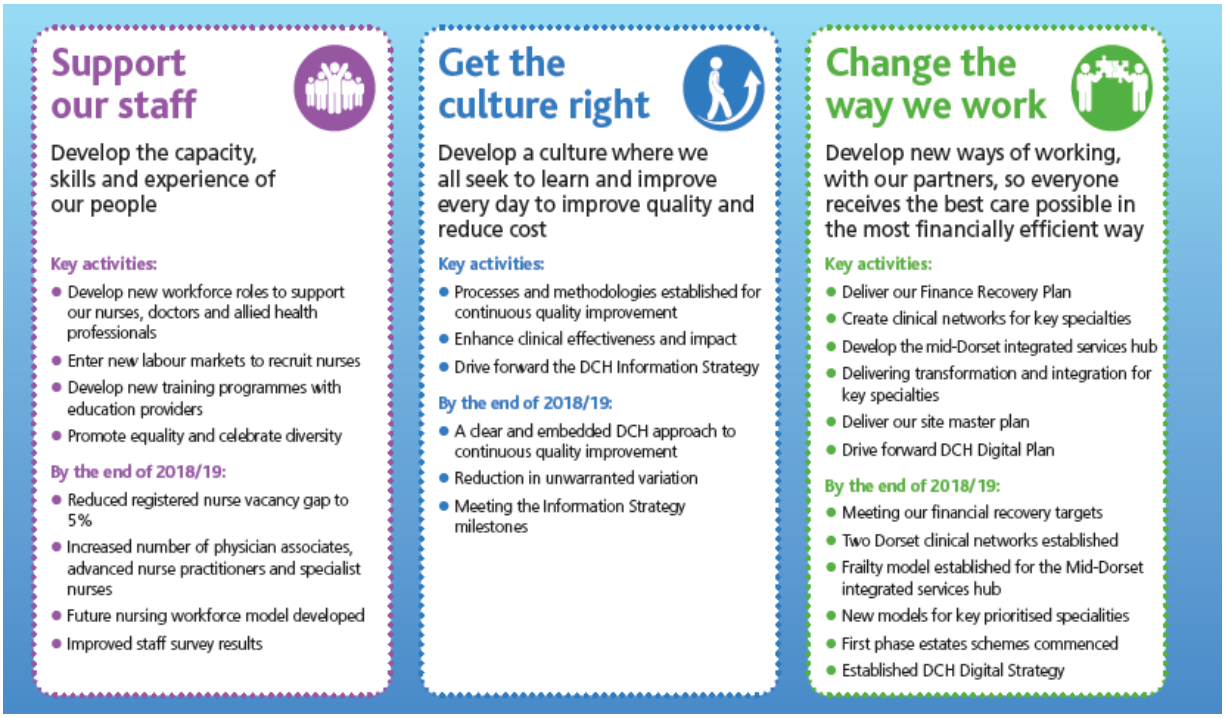
The Trust is part of the Dorset Clinical Services Review and the Dorset Sustainability and Transformation Plan both of which seek to ensure a sustainable health system for Dorset. We are working closely with our partners to design and deliver a health system which meets the needs of our population in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

As a key partner in the Dorset Integrated Care System (ICS) we have agreed an ICS Operational Plan and System wide set of financial control totals. The ICS will operate in shadow form in 2018/19 and the governance will evolve to a more formal basis over the year.

The DCH Strategy and transformational programmes (as outlined in the strategy on a page and corporate priorities documents) are aligned closely to the ICS priorities.

Separately the Trust has developed a set of operational and business plans for its core divisions and corporate services which set out how the Trust will deliver key constitutional standards, improve safety, quality and patient experience and ensure we continue to meet our medium term financial plan to achieve financial sustainability. These plans outline the Trust's commitment to the provision of safe, high quality care and improving its current Care Quality Commission rating from "Requires Improvement" to "Outstanding". The plan is based on delivering the anticipated levels of demand in line with national quality and performance standards in the most cost efficient manner.





Key Issues and Risks

Our key strategic risks are captured, monitored and managed via our Board Assurance Framework. The below provides a narrative view of some pertinent issues and risks.

Nationally the picture remains similar to last year as we continue to see the same challenges increase, across workforce and finances in particular, while national policy remains focused on integration of care and the regulatory environment continues to tighten.

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

Five Year Forward View – The NHS Five Year Forward View was published in 2014 and details how health and social care will be delivered in the next five years. The Five Year Forward View warned that a combination of growing demand and limited funding could produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. To deal with this, the document proposed a three pronged approach of demand management, improved efficiency and, if these two are delivered, an increase in funding from central government.

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

External Regulation and Oversight – a number of national bodies exist which provide oversight and inspection of the Trust's activities. Changes in policy or approach, or decisions to intervene in Trust operations, which may be influenced by various external or internal factors, may affect the delivery of the Trust's objectives. Conversely, the development of Integrated Care Systems may reduce the oversight of these bodies to be replaced by more local system governance and influence.

Local Challenges and Opportunities

Development of Integrated Care System and delivery of the Dorset Sustainability and Transformation Plan - developing a more integrated approach to the delivery of health and care is an absolute imperative. Integrated system working focusing on joint solutions to the challenges faced will be the only way that the Trust is able to deal with forecast increases in demand. Dorset is one of the leading ICS' which provides a great opportunity for greater integration and collaboration to meet the challenges we face.

However, as there is no blueprint for the way an ICS should operate there will be a need to manage the balance between system delivery and organisational governance and sovereignty.

The cornerstone of the changes set out in the Dorset STP to the Dorset health system is the reconfiguration of Royal Bournemouth and Christchurch Hospitals and Poole Hospitals. This decision is currently under judicial review. Until this is resolved there is uncertainty in delivery of this change and therefore the impact on DCH.

Additionally, while RBCH and PH work towards the significant undertaking of merging and reconfiguring services the ability to quickly implement Dorset wide solutions which will benefit DCH will be stymied.

Capacity for change - The financial challenges facing us mean that we need to focus on ensuring our short-term sustainability, while also delivering long-term transformation. These must be delivered in parallel. We must be flexible and respond and adapt quickly to emerging priorities. Currently, there is a challenge in creating the capacity to deliver strategic change while also maintaining day to day operations and standards.

Transformation delivery - DCH has a number of key transformation programmes, including the development of the Integrated Community and Primary Care Hub, successful progress of these programmes will contribute to delivering strategic change and meeting the quality and financial challenges we face. Failure to make progress will leave the Trust further away from meeting our strategic objectives.

Integrated Urgent Care - In partnership with DHC, RBCH, PH and SWAST, DCH is currently bidding for the Dorset Integrated Urgent Care contract. If successful DCH will take on delivery of Urgent out of hours primary care services. If unsuccessful a third party commercial provider will enter the Dorset system to deliver the IUC services.

Going Concern Statement

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Performance Analysis

Monitoring Trust Performance

Dorset County Hospital NHS Foundation Trust is committed to the principles of good governance and this includes a robust approach to performance management and performance improvement. The Board aspires to providing the best services within the resources available and being one of the top performing hospitals.

To reflect this, a new Performance Management Framework was established in 2017 which sets out the principles and approaches to developing a high performing organisation which successfully delivers national and local standards for quality including patient experience, operational performance, finance & use of resources. The framework seeks to encompass achievement of the broader strategic objectives agreed by the Foundation Trust Board and other enabling strategies to ensure a clear line between national requirements, contractual obligations and strategic business priorities of the Foundation Trust.

The framework aims to reflect the NHS Improvement Single Oversight Framework published in September 2016. NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers to ensure that hospitals are able to provide care that is consistently safe, high quality, compassionate, and within local health systems that are financially sustainable.

The Trust agreed performance trajectories as part of the wider Sustainability and Transformation Funding arrangement for Dorset for 2017/18 for the three key performance indicators (Emergency Department waiting times, Referral to Treatment waiting times and Cancer waiting times).

The Board monitors Trust performance against a range of key objectives and targets some of which are national targets and some which are set by commissioners. The Board Assurance Framework links to key performance indicators and ensures that the Board's focus is on the key risks to delivery of the organisation's principal objectives. This is in turn linked to the Corporate Risk Register to ensure that all necessary mitigations are in place to reduce risk wherever possible.

Operational Performance

We are extremely proud of the improvements made, now sustained throughout the year within our Emergency Department, making it one of the top performing departments in the country. This has been against a backdrop of a tougher Winter period throughout the NHS. Cases of influenza, higher demand and some extreme weather has put increased pressure on the local urgent care services, testing resilience plans on a number of occasions.

The prolonged pressures of Winter have also impacted planned care and resulted in a number of cancelled operations, impacting the already stretched performance against Referral to Treatment targets. Two periods of snow within short succession also resulted in a dip in performance against the 2-week wait standard for cancer in March as both patients and staff struggled to attend the hospital for planned appointments.

A great deal of focus has been placed on improving pathways for patients, making it easier and faster to access care. This has resulted in improvements to cancer pathways, particularly for lung cancer patients and urology patients, the programme of work with each cancer group continues as well as the networked approach across Dorset to improving cancer care. We are looking forward to the opening of the new Cancer Centre on site when the building work completes later on in 2018.

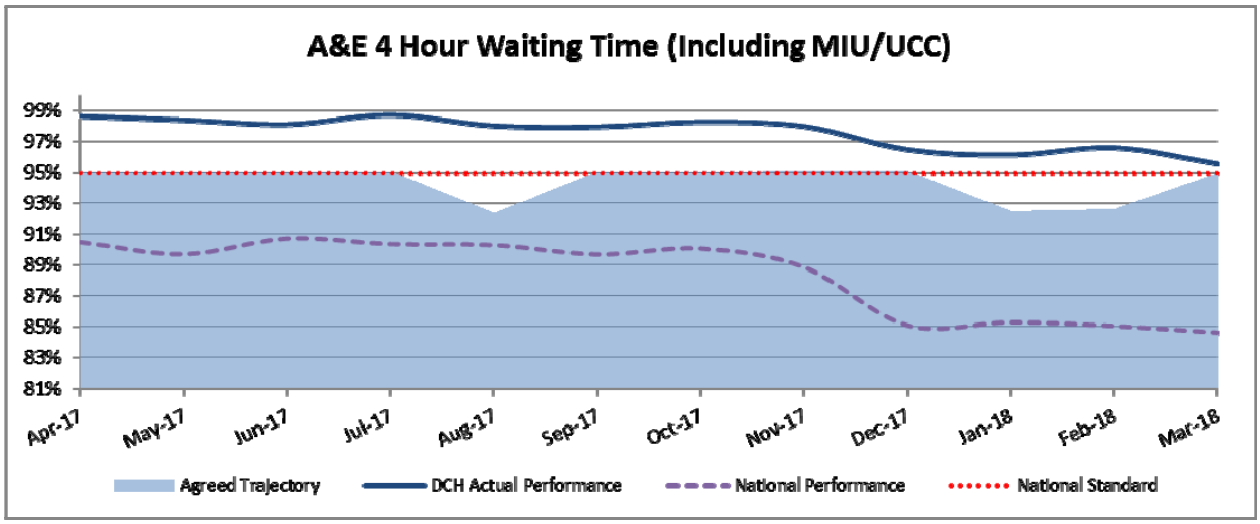
Emergency Department

Building on successes in 2016/17, the Trust has continued to work with its system partners to develop innovative and collaborative approaches to delivering urgent care and to the development of joint care pathways. Included in this was the joint delivery of the Weymouth Urgent Care Centre and the local Minor Injury Units with Dorset HealthCare University Foundation Trust. Beginning in November 2016, this joint-delivered service has provided access to urgent care in one of the most densely-populated local areas and patients are actively streamed to the local treatment centre if the presenting complaint allows for this. The opening of a fully functional Urgent Care Centre has helped to slow growth in attendance rates at the main Emergency Department site, and has helped to ensure ongoing performance against the four hour access standard.

The Dorset County Hospital main Emergency Department site achieved 95% against the four hour standard for the 2017/18 year-in-full. This indicates a marked and sustained improvement against the previous full year activity. Despite an exceptionally challenging winter period, the combined Type 1 and Type 3 performance (Emergency Department and Urgent Care Centre) for Quarter Four was 96%, and in March was 95.5%. This ranks the Trust as one of the top performing Trusts against this measure in the country. Dorset County Hospital was one of the only three Trusts in the Country to achieve the four hour standard in March 2018.

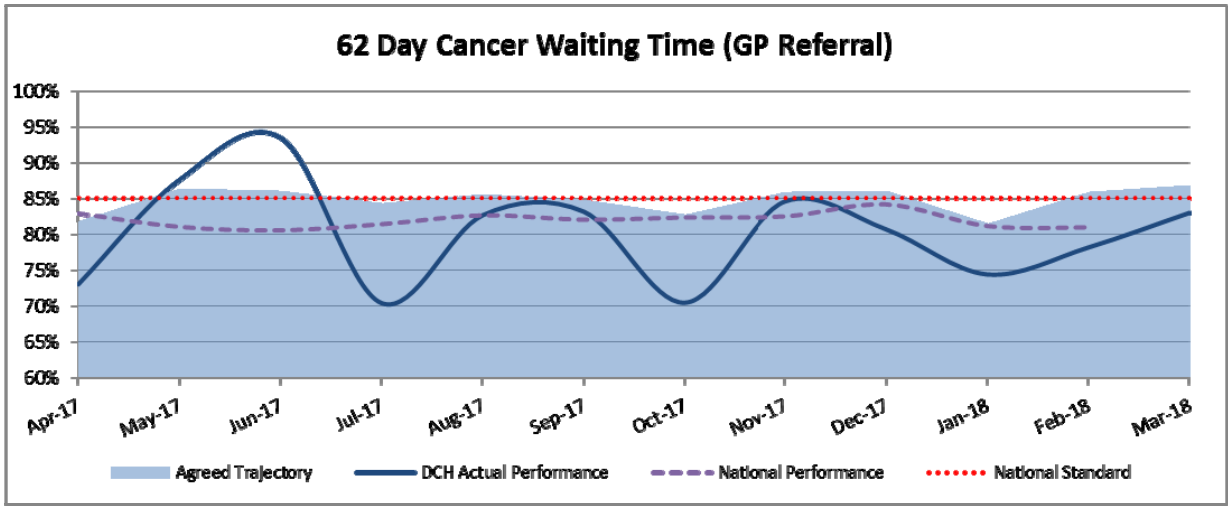
The national picture shows that achievement of the four hour standard remains challenging, and the Emergency Department and the wider Trust continue to work towards an outcome of continuous improvement in patient pathways and alternative treatment models. This has manifested as strengthened relationships with specialty teams, particularly the Acute Medicine service, and the development and growth of services such as the Ambulatory Emergency Care service, the Medical Day Unit, the Acute Hospital at Home service, and the Increased Access to GP service.

The Emergency Department has been recognised for its strong performance and improvement trajectory, including via a visit from Sir Bruce Keogh, Rt Hon Jeremy Hunt MP, and Sky News; further, it was included in the development of the CQC's best practice guidance for Emergency Departments.



Cancer Waiting Times

Throughout 2017/18 Dorset County Hospital consistently met the 31-day standards and the 62 day screening to treatment standard each quarter. The two-week wait standard was met in all but the first quarter of the year. As can be seen in the graph on the next page, the Trust met the 62 days from GP referral to treatment standard in the first quarter, but has subsequently missed the standard for the remaining quarters.



In Quarter 1 the Trust achieved all but the two 2WW performance standards. The concern at that time centred on capacity for the one-stop Breast appointment as this is heavily dependent on radiology capacity which was supported by only one radiologist. The Trust has since secured additional support and is able to cover the absences of the radiologist without a loss of capacity for the service.

In Quarters 2 and 3 it became difficult to achieve the 62 day standard (from GP referral), however all other standards were met. Capacity constraints, increasing numbers of difficult to diagnose and treat cancers and complex presentations all contributed to the challenges for treatment within 62 days of referral. The introduction of a new referral form earlier in the year reduced the number of risk factors needed to trigger a referral, the expectation was that patients with difficult to detect cancers would be referred earlier than traditionally seen. As a consequence of this change the Trust saw a rise in referrals for suspected cancers in head and neck, lung and upper gastro-intestinal sites. Patients on these pathways can experience numerous tests before cancer can be either excluded or confidently confirmed and therefore breaches are more common in these longer pathways.

In quarters 3 and 4 the Trust successfully secured assistance from NHS Elect as part of the NHS Cancer Collaborative; coaching was offered and review work was undertaken to reduce variation within pathways through service improvements. Additional funding from NHS England was also secured, which attracted an additional £220k into the Dorset system and allowed some increased diagnostic sessions, training within tumour sites to increase flexibility within the workforce and additional histopathology sessions. The positive impact of this package, together with increased internal focus on roles and responsibilities within pathway management can be seen in the steadily improving performance in Quarter 4.

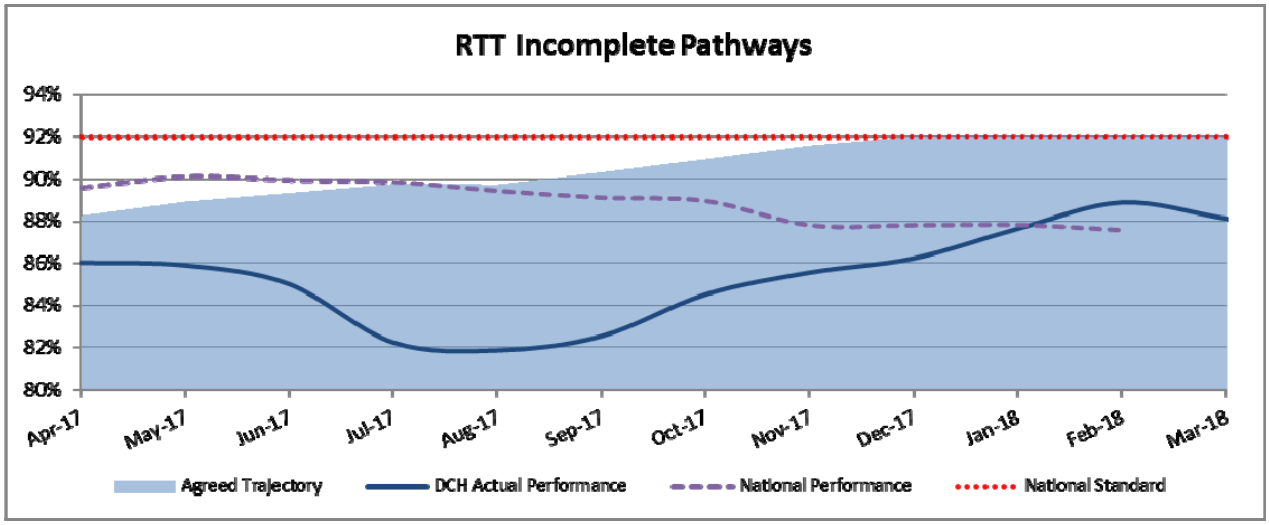
Referral to Treatment Times

The Trust has required a high level of focus on this standard during 2017/18 due to pressures in a number of specialty areas which were performing below the standard. There has been a programme of improvement in place and regular monitoring of progress. Ophthalmology has continued to be the area with the largest number of patients waiting over the waiting time standard. Significant investment has been made into the service to increase capacity for treating patients and changes to pathways made to make sure those patients who need to be seen are seen quickly.

There have been changes to the local services for musculoskeletal conditions which aim to reduce referrals to acute hospitals and manage patients more conservatively before considering invasive treatments. It is expected that this will reduce waiting times for those patients who are referred on to acute services.

Performance has improved since Aug 17, from 81.9% to 88.12% at the end of March 18. Furthermore, the waiting list has fallen by 989 patients from Aug 17 of which 881 were over 18+. Ophthalmology continues to improve, with 87% of patients being treated in 18 weeks, compared to 51% in August 2017.

The graph below shows the improvements made during the year:



Summary

The Trust is delighted with the performance in Emergency Care sustained throughout the year and continues to work to improve patient experience working with our system partners to support care outside of hospital, particularly for frail elderly patients.

This has been a challenging year for both Cancer and Referral to Treatment performance, and vast improvements have been made to achieve the targets, this work will continue into 2018/19 to ensure equally high performance consistently for these areas.

Establishing network-wide links and support from National partners such as NHS Elect has supported the Trust to ensure the best care for patients locally both now and for the future.

Our Financial Performance

In 2017/18, the Trust's financial plan recognised the increased demand for NHS services, bringing with it increasing financial pressures, which are being experienced across the country. Therefore the Trust's plan, highlighted significant financial challenges in delivering a deficit of £2.9 million.

The Trust delivered surplus of £1.5 million, this equates to approximately 0.8% of the Trust's turnover. Table 1 below sets out the Trusts adjusted surplus of £0.9 million as assessed by NHS Improvement this excludes impairment movements (changes in the value of land and buildings) in year of £0.2 million and the movements linked to donated capital assets of £0.4 million.

Table 1 : Financial Performance against plan	2017/18 Plan £ millions	2017/18 Actual £ millions	Variance £ millions
Total income	169.7	180.7	11.0
Total expenses	-172.6	-179.2	-6.6
Operating deficit/surplus	-2.9	1.5	4.4
Capital donations	-0.4	-0.8	-0.4
Donated depreciation	0.4	0.4	0.0
Impairments	0.0	-0.2	-0.2
Adjusted deficit/surplus	-2.9	0.9	3.8

The Trusts improved financial position of £3.8 million is mainly linked to central funding from the Sustainability and Transformation Fund of £3.4 million.

Sustainability and Transformation Funding
The financial plan included £4.1 million Sustainability and Transformation Funding (STF) from NHS Improvement which required us to achieve agreed financial and performance targets.

The Trust achieved these targets and therefore earned additional funding from the STF incentive scheme of £0.9 million. At the end of the year a further STF bonus of £2.5 million was also awarded, bringing total STF funding in 2017/18 to £7.5 million, £3.4 million above plan.

Performance Against Plan
Income exceeded our financial plan, leading to a favourable variance of £11 million, of which £3.4 million is from Sustainability and Transformation Funding and £1.7 million is overachievement of the income target included in the Trust's Cost Improvement plan. Expenditure was £6.6 million above plan, of which £1.7 million is underachievement of the Cost Improvement Plan delivered through additional income.

Capital donations towards the cost of the capital programme also exceeded the original expectations, set out in our financial plan of £0.4 million. The annual revaluation of the Trust's land and building led to a reversal of an impairment from a previous financial year, this reversal of impairment represents a technical accounting adjustment that is reflected in our final financial position

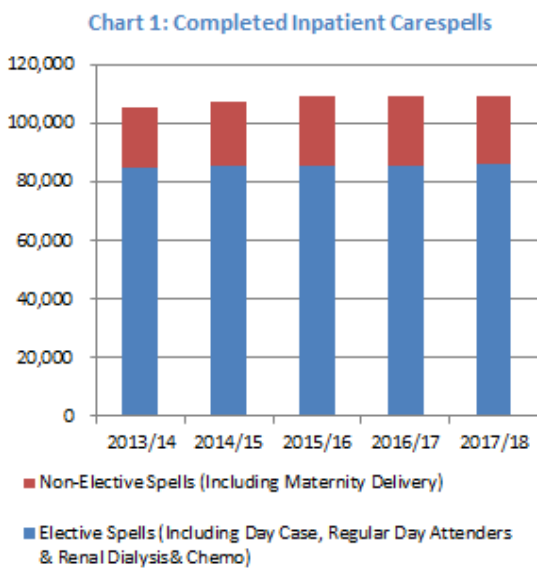
Cost Improvement Programme
At the start of the year, the Trust set an £8.8 million Cost Improvement Programme (CIP), reflecting the level of savings required to deliver our financial plan, achieve national efficiency targets and treat patients within the funding available from our commissioners.

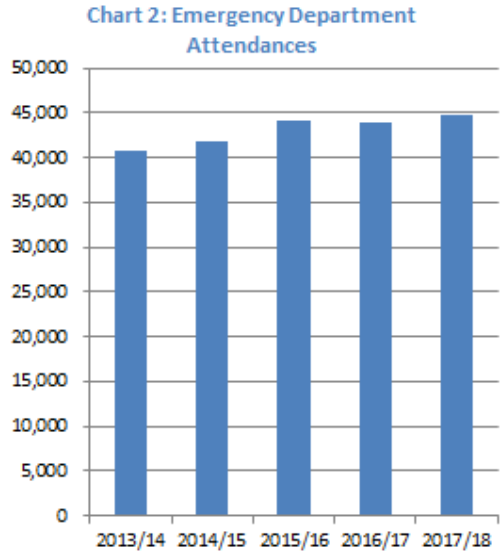
This target was met through a range of efficiency measures and additional income. Local savings at division level were complemented by Trust-wide savings; these were delivered through Better Value Better Care and focused on improved quality, safety and efficiency.

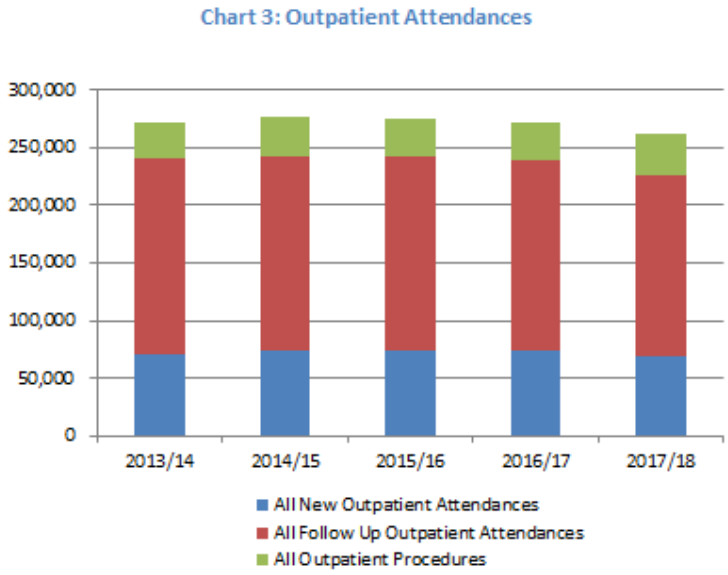
Trends in Activity, Income and Expenditure

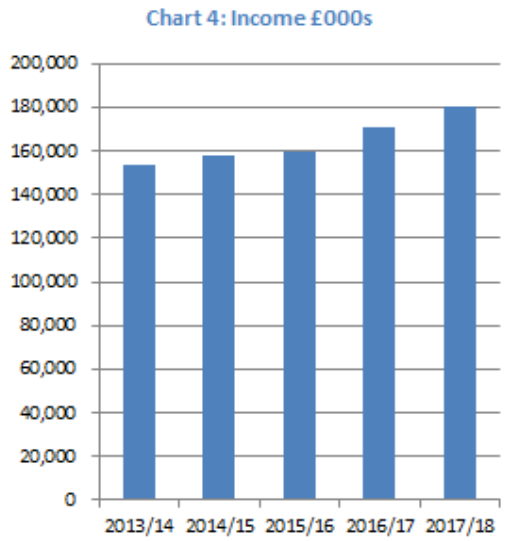
Charts 1 to 5 below show the trends in patient activity and income and expenditure over the five-year period from 2013/14 to 2017/18

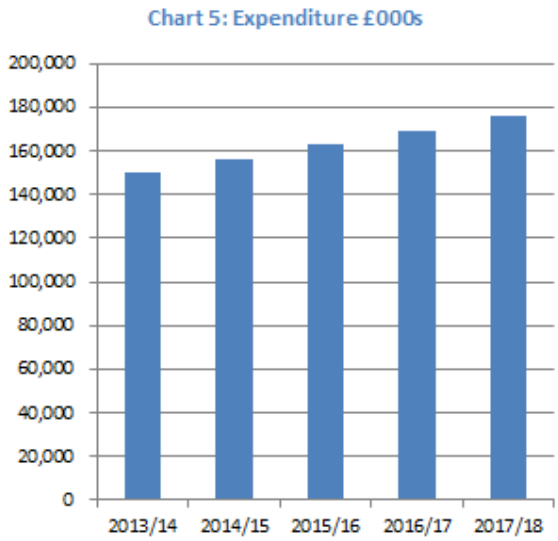
Trends in Activity, Income and Expenditure (Five Years)











Activity Trends

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

The majority of growth in inpatient and day case activity relates to an increase in non-elective admissions of 11%.

Emergency Department attendances are up 10% over the five-year period. This reflects the national challenges to NHS Emergency Departments across the country.

Total outpatient activity has reduced over the five-year period. The majority of this is due to a reduction in the numbers of follow up outpatient attendances.

Chart 4 shows the growth in income over the five-year period from April 2013 to March 2018. This growth in income is at an average rate of 4% a year over the five-year period. This is primarily the result of the Sustainability and Transformation Fund Income and the transfer of services to the Trust.

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

Cash Flow

The Trust ended the year with £2.5 million cash at bank. This was a decrease of £1.9 million during the year. The decrease in the cash was due to the investment in infrastructure through its capital programme, which was linked to the managed underspend in the 2016/17 capital programme of £2.0 million.

Revaluation of land and buildings

As part of the preparation of the annual accounts, the Trust is required to assess the value of its land and buildings. This exercise is carried out at the end of the financial year. This year, these were valued independently by Bilfinger GVA, in line with accounting policies.

Overall there was an increase in the valuation of land and buildings of £0.32 million. This included a charge to the Revaluation Reserve of £0.16 million and a charge to other operating expenses in the Consolidated Statement of Comprehensive Income for reversals of previous year impairments of £0.16 million.

Charitable Funding
The Trust is fortunate to be supported by Dorset County Hospital Charity and a number of other local charities. All Dorset County Hospital Charity funds benefit the Trust. In 2017/18, the Trust received charitable grants for capital projects from the Charity of £0.8 million. This included funding for the new Cancer facilities at Dorset County Hospital.

Capital Expenditure
Capital expenditure during 2017/18 was focused on backlog maintenance, the provision of medical equipment and investment in IT projects. The Trust's capital plan is set through a risk based approach to ensure continuity of patient care. The Trust set its capital plan at £7.3 million and incurred expenditure of £8.0 Million, with the additional £0.7 million funded from monies received from its charity for the new Cancer facilities of £0.7 million. The Trust's major developments were the completion of the refurbishment of the current Catheter Laboratory and the completion of the Digital Patient Record which went live during quarter four of the financial year.

Environmental Performance

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

Social Community and Human Rights Issues

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

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

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

Counter Fraud and Anti-bribery activity

There was a programme of counter fraud and anti-bribery activity, supported by the Local Counter Fraud Specialist (LCFS) whose annual work plan of prevention, deterrence and detection was monitored by the Chief Finance Officer, the Director of Finance and the Audit Committee.

The LCFS regularly attends Audit Committee meetings and ensures that the Trust is compliant with the national standards for countering NHS fraud, as issued by NHS Protect. Counter Fraud material was disseminated to staff through the intranet.

To publicise both the existence of the counter fraud initiative and the understanding that everyone has a role to play in tackling fraud occurring within the CCG, the LCFS delivered Fraud and Bribery Act awareness training to a variety of staff both at induction and through staff presentations to Wards, Departments (including the Finance Department). The LCFS reviewed several policies; policies are reviewed in line with current legislation and from a best practice and counter fraud perspective.

Events After the Reporting Period

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

Overseas Operations

The Trust has no overseas operations.

Patricia Miller
Chief Executive
22 May 2018

Accountability Report

Directors' Report

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

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

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

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

The Trust has adopted the Better Payment Practice Code, which requires it to aim to pay all undisputed invoices by their due date, or within 30 days of receipt of goods or a valid invoice. The application of this policy resulted in a supplier payment period of 37 days for the Trust's trade payables as at 31 March 2018 (2017: 35 days). The Trust incurred interest and compensations charges of £439 during 2017/18 (2016/17 £160) under the Late Payment of Commercial Debt (Interest) Act 1998. The performance of the Trust in complying with the Code were as follows:

	2017/18		2016/17	
	Number	Value £000	Number	Value £000
Trade payables				
Total bills paid in year	**50,117**	**63,222**	48,901	73,345
Total bills paid within target	**44,017**	**51,627**	37,699	55,269
Percentage of bills paid within target	**88%**	**82%**	77%	75%
NHS payables				
Total bills paid in year	**1,641**	**9,726**	1,872	13,265
Total bills paid within target	**1,137**	**6,897**	1,399	10,330
Percentage of bills paid within target	**69%**	**71%**	75%	78%

The Trust has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), by ensuring the income from the provision of goods and services for the purposes of the health service in England are greater than income from the provision of goods and services for any other purposes. The income from provision of goods and services for any other purpose was £896k which represents 0.50% of total Trust income. The Trust's financial planning ensures the requirement is maintained in the future and that any income for other purposes is contributing a profit for reinvestment into health services in England.

Delivery of the Trust's quality priorities are based on the principles of strategy, capability and culture, structures and measurement as described in the Well Led Framework. Oversight of the Trust's service quality is undertaken by the Quality Committee which meets on a monthly basis. The Quality Committee is Chaired by a Non-Executive Director. Both the minutes and a verbal update by the Chair of the committee are received by the Trust Board. Further detail on the quality and quality governance are provided within the Quality Report, Performance Report and Annual Governance Statement, the Quality Report and the Care Quality Commission Report.

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

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

Preparing for Major Incidents

The Trust needs to be able to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak, a major transport accident or a terrorist act.

The Civil Contingencies Act (2004) requires NHS organisations and providers of NHS funded care, to plan and prepare for such incidents, whilst maintaining safe services to patients. This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR). There are a set of NHS EPRR Core Standards, issued by NHS England, against which the Trust declared fully compliant with 58 of the standards and partially compliant with 2 of the standards. An action plan was delivered to ensure that the Trust became fully compliant with all standards by March 2018. The overall rating of compliance and preparedness was 'Substantial Compliance'.

Remuneration Report

Annual Statement on Remuneration

As Chairman of the Remuneration and Terms of Service Committee, I am pleased to present the Remuneration Report for 2017/18.

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

For 2017/18 the Committee approved the recommendation to apply 1% to all Executives, as opposed to differentiating the award. In reaching its conclusions on salary adjustments, the Committee considered relative position in range in terms of the national benchmark data, and local Dorset provider benchmark data. The relative position of each Executive was considered and the decision was made to make a salary adjustment to the Chief Executive. The Committee made an award that was inclusive of the 1% salary increase agreed for all Executive Directors.

Mark Addison
Remuneration and Terms of Service Committee Chair
22 May 2018

Senior Managers Remuneration Policy

Policy on Remunerations of Senior Managers

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

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

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

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

Salary + Pension and Benefits = Total remuneration

Future Policy Table

The Trust's remuneration policy in respect of each of the above is outlined in the tables on the next page.

Salary – (Fees and Salary)

Purpose and Link to Strategy

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

Operation

Base salaries are set to provide the appropriate rate of remuneration for the job, taking into account relevant recruitment markets, business sectors and geographical regions.
The Remuneration Committee considers the following parameters when reviewing base salary levels:

- Pay increases for other employees across the Trust
- Economic conditions and governance trends
- The individual's performance, skill and responsibilities through appraisals
- Base Salaries at NHS organisations of similar size are benchmarked against Dorset County Hospital NHS Foundation Trust
- Base Salaries are paid in 12 equal monthly instalments via the regular monthly employee payroll
- The Executive Directors do not receive performance related pay.

Opportunity

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

National and Local benchmarking data was reviewed by the Remuneration Committee who reviewed the relative position of each Executive.

Performance Conditions

None, although performance of both the Trust and the individual are taken into account when determining whether there is a base salary increase each year. The individual receives an annual appraisal to review performance and set objectives.

Performance Period

Annual Appraisal covers a 12 month period

Pension and Benefits

Purpose and Link to Strategy

- Help to recruit and retain
- NHS Pension scheme arrangements provide a competitive level of retirement income

Operation

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

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

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

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

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

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

Opportunity

The maximum Employers' contribution to NHS Pension Scheme is 14.38% of base salary for all employees including Executive Directors.

Performance Conditions

None

Performance Period

None

Differences in Remuneration for Other Employees

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

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

Where one or more senior managers are paid more than £150,000, the committee is required to ensure this remuneration is reasonable. The Trust has one senior manager paid more than £150,000. The committee is satisfied the salary of this individual is reasonable when compared to the benchmarking provided in setting the senior managers' salaries.

Policy on Remuneration of Non-Executive Directors

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

Annual Report on Remuneration

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

Remuneration and Terms of Service Committee

Remuneration and Terms of Service for the Chief Executive and Executive Directors is considered by a Remuneration and Terms of Service Committee consisting of the Chair and Non-Executive Directors. During 2017/18 the Committee met to review Executive Directors' Remuneration, the Very Senior Manager Reward Policy and Clinical Excellence Awards.

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

Name	Attendance/Meetings eligible to attend
Mr M Addison (Trust Chair) (Chair)	3/3
Mr M Rose	3/3
Mr G Stanley	2/2
Mr P Greensmith	2/3
Mr I Metcalfe	1/1
Prof S Atkinson	2/3
Ms V Hodges	3/3
Ms J Gillow	2/3

Senior Managers Service Contracts

The table below contains contract information on the Trust's Senior Managers for the financial year 2017/18.

Name	Title	Current Tenure	Notice Period
Non- Executive Directors			
Mr Mark Addison	Chair	24/03/16 – 23/03/19	3 months
Mr Peter Greensmith	NED, Vice Chair	01/06/17 – 31/05/20	3 months
Mr Graeme Stanley	NED, Senior Independent Director	01/10/16 – 30/09/19 (left 31/10/17)	3 months
Mr Matthew Rose	NED	17/06/17 – 16/06/20	3 months
Ms Victoria Hodges	NED	01/09/16 – 31/08/19	3 months
Ms Judy Gillow	NED	01/09/16 – 31/08/19	3 months
Prof Sue Atkinson	NED	01/09/16 – 31/08/19	3 months
Mr I Metcalfe	NED	01/11/17 – 30/10/20	3 months
Executive Directors			
Ms Patricia Miller	Chief Executive	Commenced 15/09/14	6 months
Ms Libby Walters	Director of Finance and Resources	Commenced 12/09/12	3 months
Mr Paul Lear	Medical Director	Commenced 01/10/11	3 months

Ms Julie Pearce	Chief Operating Officer	Commenced 26/05/15	3 months
Mr Mark Warner	Director of Organisational Development and Workforce	Commenced 02/03/15	3 months
Ms Nicky Lucey	Director of Nursing and Quality	Commenced 01/09/16	3 months
Mr Nick Johnson	Director of Strategy and Business Development	Commenced 01/02/16	3 months

Expenses of Governors and Directors

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

	2017/18 Number receiving expenses / total	£	2016/17 Number Receiving Expenses / total	£
Governors	**9 / 23**	**1,026**	**8 / 32**	**1,127**
Chairman and non-executive directors	**5 / 7**	**3,298**	**6 / 8**	**4,271**
Executive directors	**7 / 7**	**9,479**	**8 / 8**	**11,993**
Total expenses		**13,803**		**17,391**

The following sections of the Remuneration Report are subject to audit

The total remuneration of directors and senior managers for 2017/18 was £819,600 (2016/17: £802,700).

Remuneration of Directors - 2017/18	Fees and salary (Bands of £5,000) £ 000s	Taxable benefits (nearest £100)	Pension related benefits (Bands of £2,500) £ 000s	**2017/18 Total (Bands of £5,000) £ 000s**
Chairman				
Mr M Addison	40 – 45	-	-	**40 – 45**
Non-executive Directors				
Mr P Greensmith	10 – 15	-	-	**10 – 15**
Ms J Gillow	10 – 15			**10 – 15**
Prof S Atkinson	10 – 15	-	-	**10 – 15**
Ms V Hodges	10 – 15	-	-	**10 – 15**
Mr M Rose	10 – 15			**10 – 15**
Mr G Stanley[1]	5 – 10	-	-	**5 – 10**
Mr I Metcalfe[2]	5 – 10	-	-	**5 – 10**
Executive Directors				
Ms P Miller, Chief Executive	160 –165	-	50 – 52.5	**215 –225**
Mr P Lear, Medical Director	75 – 80	-	-	**75 – 80**
Ms N Lucey, Director of Nursing & Quality	120 –125	-	22.5 – 25	**145 –150**
Ms J Pearce, Chief Operating Officer and Interim Director of Nursing and Quality	120 –125	-	15 – 17.5	**135 –140**
Mr M Warner, Director of Organisational Development and Workforce	115 –120	-	55 – 57.5	**170 –175**
Ms L Walters, Director of Finance & Resources	110 –115	-	25 – 27.5	**135 –140**
Mr N Johnson, Director of Strategy and Business Development	105 –110	-	-	**105 –110**

Remuneration of Directors - 2016/17	Fees and salary (Bands of £5,000) £ 000s	Taxable benefits (nearest £100)	Pension related benefits (Bands of £2,500) £ 000s	**2016/17 Total (Bands of £5,000) £ 000s**
Chairman				
Mr M Addison	40 – 45	-	-	**40 – 45**
Non-executive Directors				
Prof M Earwicker[3]	5 – 10	-	-	**5 – 10**
Mr P Greensmith	10 – 15	-	-	**10 – 15**
Ms J Gillow[4]	5 – 10	-	-	**5 – 10**
Prof J Reid[5]	5 – 10	-	-	**5 – 10**
Prof S Atkinson[6]	5 – 10	-	-	**5 – 10**
Ms V Hodges[7]	5 – 10	-	-	**5 – 10**
Mr M Rose	10 – 15	-	-	**10 – 15**
Mr G Stanley	10 – 15	-	-	**10 – 15**
Executive Directors				
Ms P Miller, Chief Executive	155 –160	-	42.5 - 45	**200 – 205**
Mr P Lear, Medical Director	80 – 85	-	-	**80 – 85**
Ms N Lucey, Director of Nursing & Quality[8]	65 – 70	-	32.5 - 25	**100 – 105**
Ms J Pearce, Chief Operating Officer and Interim Director of Nursing and Quality[9]	115 –120	-	0 – 2.5	**120 – 125**
Ms C A Tong, Director of Nursing & Quality[10]	40 – 45	-	20 – 22.5	**60 – 65**
Mr M Warner, Director of Organisational Development and Workforce	110 –115	-	35 – 37.5	**145 – 150**
Ms L Walters, Director of Finance & Resources	110 –115	-	45 – 47.5	**155 – 160**
Mr N Johnson, Director of Strategy and Business Development	100 – 105	-	-	**100 – 105**

1 – Resigned on 31 October 2017
2 – Appointed on 1 November 2017
3 – Resigned on 30 September 2016
4 – Appointed on 1 September 2016
5 – Resigned on 31 August 2016
6 – Appointed on 1 September 2016
7 – Appointed on 1 September 2016
8 – Appointed on 1 September 2016
9 – Acting until 30 August 2016
10 – Resigned on 1 August 2016

There were no annual performance related or long term performance related bonuses paid during the year 2017/18 or 2016/17.

There have been no payments during 2017/18 to individuals who were senior managers in the current or in a previous financial year for loss of office.

There have been no payments to past senior managers during 2017/18.

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

The banded remuneration of the highest-paid director in the Trust in financial year 2017/18 was £160,001 to £165,000 (2016/17: £155,001 to £160,000). This was 6.11 times (2016/17: 5.99 times) the median remuneration of the workforce, which was £26,614 (2016/17: £26,302).

In 2017/18, 6 (2016/17: 9) employees received remuneration in excess of the highest paid director. Remuneration ranged from £167,600 to £189,200 (2016/17: £160,000 to £195,000).

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

The multiple for 2017/18 has increased due to the change in the median remuneration and the salary adjustment to the Chief Executive.

The median remuneration of the workforce in 2017/18 falls within the salary range of a Foundation Doctor year 1 (2016/17 falls within the salary range of a Band 5 position under the Agenda for Change terms and conditions that apply to all non-medical staff). The actual salary of staff within each band is dependent on a number of factors, the most significant being the number of years they have served in that position.

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

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

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

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

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

	Real Increase / (decrease) in pension at retirement (bands of £2,500) £000	Real Increase / (decrease) in lump sum at retirement (bands of £2,500) £000	Total accrued pension at retirement at 31/03/2018 (bands of £5,000) £000	Related lump sum at retirement at 31/03/2018 (bands of £5,000) £000
Ms P Miller, Chief Executive	2.5 - 5.0	0 - 2.5	35 – 40	80 – 85
Mr M Warner Director of Organisational Development and Workforce	2.5 - 5.0	0 - 2.5	15 – 20	0 – 5
Ms J Pearce, Chief Operating Officer and Interim Director of Nursing and Quality	0 - 2.5	2.5 - 5	55 – 60	165 – 170
Ms L Walters, Director of Finance & Resources	0 - 2.5	0 - 2.5	35 – 40	95 – 100
Ms N Lucey, Director of Nursing & Quality	0 - 2.5	2.5 - 5	45 – 50	135 – 140

	Cash Equivalent Transfer Value at 31/03/2018 £000	Cash Equivalent Transfer Value at 01/04/2017 £000	Real increase in Cash Equivalent Transfer Value £000
Ms P Miller, Chief Executive	594	546	43
Mr M Warner Director of Organisational Development and Workforce	240	190	48
Ms J Pearce, Chief Operating Officer and Interim Director of Nursing and Quality	1278	1175	91
Ms L Walters, Director of Finance & Resources	567	505	56
Ms N Lucey, Director of Nursing & Quality	819	731	47

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

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

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

Patricia Miller
Chief Executive
22 May 2018

Staff Report

Valuing Our Staff

As a major local employer of 2,500 staff, who fulfil a wide range of professional and multidisciplinary roles, we recognise that our workforce defines who we are and how we are viewed by the patients and carers we serve. We strive to ensure our staff are highly skilled and well supported in their working environment, in order that they are able to deliver the highest standards of compassionate and safe care. Investment in the recruitment, education, training, support and well-being of our staff is an important consideration for us.

Recruitment

The national shortage of nursing and medical staff has meant that recruitment in to these posts remained challenging throughout 2017. The trust employed a number of measures to increase recruitment activity including attending recruitment events across the country as well as hosting a local event advertised through radio and social media. The trust took part in an overseas recruitment campaign in Dubai. It is anticipated that this in conjunction with domestic recruitment will fill most of our nursing vacancies in 2018.

Employment Policies

The Trust has in excess of 70 employment policies in place which have been designed to provide guidance to our staff and to ensure we meet our legal obligations to them. The effectiveness of each policy is reviewed in conjunction with staff representatives every three years as a minimum, but most are reviewed more frequently due to changes to employment law or best practice or in response to feedback from staff. During 2017, 21 of our employment policies were reviewed to ensure effectiveness and adherence to legal requirements.

Appraisal Process

A values based appraisal process for non-medical staff was launched in October 2016. A review has recently been undertaken and some improvements made based on feedback from appraisers and appraisees. Through the staff opinion survey, 84% of staff confirmed they had clear objectives set for their work and 81% of staff confirmed their recent appraisal left them feeling valued by the organisation.

Staff Gender Analysis (as at 31 March 2018)

	At 31 March 2018
Board directors by gender;	
Male	7
Female	7
Employee headcount by gender (full-time equivalent basis)	
Male	571
Female	1,765
Total	2,336

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

	2016	2017
Total days lost	17,666	16,228
Total staff employed (Full-time equivalent basis)	2,267	2,291
Average working days lost per employee	7.8	7.1

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

In 2017, we were pleased to renew our Disability Confident accreditation, which replaced the 'Two Ticks' symbol in 2016. This guarantees an interview for any disabled person who meets the minimum criteria for a role. Disability Confident status is awarded by Job Centre Plus to employers and signifies our positive attitude towards employing and retaining disabled staff and developing their abilities. The Trust policies aim to help prospective and current employees who may become disabled with a range of reasonable adjustments that enable them to return to and remain in work.

The Trust provides on-going skills training in Equality and Diversity to all staff; this covers steps that the Trust and staff must take in order to promote equality of opportunity for staff and patients across all protected characteristics. The Trust seeks to encourage all of our staff to value the possibilities in each other and explore the opportunities that difference brings. During 2017 our Equality & Diversity Steering Group continued to meet quarterly to oversee this important agenda.

Consultation, Partnership Working and Staff Engagement
We have a number of established mechanisms of communicating information across the Trust, including a weekly email bulletin, a weekly email briefing from the Chief Executive, monthly team briefing sessions and a quarterly staff magazine. The Trust also communicates stories of interest via social and local media. Our established consulting and negotiating bodies, the Partnership Forum (for non-medical staff) and Local Negotiating Committee (for medical staff), continue to make an important contribution to promoting effective staff engagement and partnership working and in ensuring these are underpinned by a commitment to: promoting the success of the organisation; recognising the respective parties' legitimate interests; operating in an honest and transparent manner; focusing on the quality of working life and its benefit to the quality of patient care; maintaining, as far as possible, employment security.

The Trust also takes part in the national staff survey annually and a quarterly local staff survey. Our People Strategy and Trust values were launched in 2015. In 2017 we have developed this work further, embedding our values into our systems and procedures, including values based appraisal and values based induction. Our People Strategy is currently under review and will be relaunched during 2018.

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

In 2017 we launched Care First; our Employee Assistance Programme. Care first are a leading provider of professional counselling, information and advice offering support for issues arising from home or work. They employ professionally qualified Counsellors and Information Specialists, who are experienced in helping people to deal with all kinds of practical and emotional issues.

All staff can access Care First, who will provide additional support in both work and non-work related matters. From work-life balance to childcare information, relationships to workplace issues, health & wellbeing. Topics include (but are not limited to) debt, disability & illness, bereavement & loss, stress, elder care information, life events, anxiety & depression, family issues, education, consumer rights. Care First is free of charge and staff don't need to ask their manager, they can call them directly to speak to a professional counsellor or information specialist in confidence. All staff also have access to confidential counselling via Care First and can self-refer themselves for fast track physiotherapy treatment for joint or muscle pain. Staff are encouraged to take a proactive approach to their wellbeing. During the latter part of the year, the Trust took part in the seasonal flu campaign, aiming to vaccinate as many frontline staff as possible against the influenza virus in order to protect patients, visitors to the hospital, staff and their families. 63.23% of staff received the vaccine at work, a significant improvement on last year's uptake rate.

Countering Fraud and Corruption
The Trust's Counter Fraud Policy sets out the standards of honesty and propriety expected of staff and encourages employees to report any suspicious activity that might indicate fraud or corruption promptly. The policy links to the Trust's Raising Matters of Concern (Whistleblowing) and Disciplinary policies and various NHS publications on this subject.

The Trust's counter fraud service continues to be provided by TIAA who report directly to the Director of Finance and Resources and also report regularly to the Audit Committee throughout the year. Raising awareness of the need to counter fraud and corruption is taken seriously by the Trust and is communicated via a variety of methods, including leaflets, counter fraud newsletters and notices, staff bulletins, staff awareness presentations, induction training and the Trust's intranet.

In response to guidance from the Care Quality Commission (CQC) that clarified that the role of Freedom To Speak Up (FTSU) Guardian should be separated from the Senior Independent Officer (SIO) and Whistleblowing Lead roles; the Trust has appointed two FTSU Guardians, one in each of the two clinical divisions, who undertake this role alongside their substantive post. The FTSU Guardians have a regular meeting with the Chief Executive, Director of Workforce and Organisational Development and Senior Independent Officer, to discuss and raise any concerns.

The Trust's Senior Independent Officer (SIO) and Whistleblowing Lead is one of our Non-Executive Board members. This role is in place to ensure there is a direct point of contact on the Board, and to provide Board level visibility of any potential issues.

What our Staff Say
Annually, we participate in the NHS national staff survey. In 2017 we surveyed all our staff. The Trust's overall score for staff engagement (measured on a scale of 1 to 5, where five is the best score) was 3.84, which was above the national average of 3.79 for Acute Trusts. Overall the results show a relatively good overall picture with most findings in line with national norms. The latest results

show that no significant changes have been made across any of the 32 key findings, showing sustained levels of staff engagement. Results show high consistency with acute national averages. Whilst this is encouraging, it is clear that key areas require further development and we will continue to work with staff representatives to address concerns raised through staff surveys held at national and local level with the aim of improving the working lives of staff. The response rate to the staff survey and highest and lowest ranking scores were as follows:

	2016/17 Trust	National Average	2017/18 Trust	National Average	Trust Improvement / Deterioration
Response Rate	54%	44%	49%	44%	5% deterioration

Top 5 Ranking Scores	2016/17 Trust	National Average	2017/18 Trust	National Average	Trust Improvement / Deterioration
% of staff believing that the organisation provides equal opportunities for career progression or promotion (higher = better)	91%	87%	92%	85%	1% improvement
Recognition and value of staff by managers and the organisation (higher = better)	3.46	3.45	3.56	3.45	0.10 improvement
% of staff experiencing discrimination at work in the last 12 months (lower = better)	10%	11%	9%	12%	1% improvement
% of staff feeling unwell due to work related stress in the last 12 months (lower = better)	34%	35%	33%	36%	1% improvement
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (lower = better)	25%	27%	25%	28%	No change

Bottom 5 Ranking Scores	2016/17 Trust	National Average	2017/18 Trust	National Average	Trust Improvement / Deterioration
Quality of non-mandatory training, learning or development (higher = better)	4.01/5	4.05/5	3.99/5	4.05/5	0.02 deterioration
% of staff / colleagues reporting most experience of violence (higher = better)	68%	67%	63%	66%	5% deterioration
% of staff / colleagues reporting most experience of harassment, bullying or abuse (higher = better)	46%	45%	42%	45%	4% deterioration
Staff confidence and security in reporting unsafe clinical practice (higher = better)	3.58%	3.65%	3.59%	3.65%	0.01% improvement
Fairness and effectiveness of procedures for reporting errors, near misses and incidents (higher = better)	3.67%	3.72%	3.68%	3.73%	0.01% improvement

The Trust also gauges staff responses in each quarter as to whether they would recommend

the Trust to family or friends as a place to work. In quarters 1, 2 and 4 this information is gathered via the staff friends and family test (Staff FFT); in quarter 3 this test forms part of the national staff survey.

	2015	2016	2017
Dorset County Hospital	63%	65%	66%
National Average	59%	59%	61%

The Trust has taken a number of actions to improve staff satisfaction and in turn the quality of its services. Actions taken in 2017 in response to staff feedback include a review of the appraisals, leadership development training being rolled out to staff within bands 4-6 and the development of a number of initiatives focusing on staff wellbeing.

Celebrating Success

Every day, individuals and teams within the Trust go above and beyond the call of duty. Our annual GEM (Going the Extra Mile) Awards have become a well-established means of recognising and honouring staff and volunteers for their service and outstanding contribution to the care of patients and running of the hospital. Staff, patients, their relatives, members of the public and volunteers took the opportunity of nominating those individuals who they judged met the criteria for each of the Trust's nine award categories and best exemplified our values. The hard work and dedication of the nominees were celebrated at a presentation ceremony held in June at the Weymouth and Portland

national sailing Academy. The event was hosted by the Chairman, Mark Addison and Patricia Miller, Chief Executive, who personally congratulated staff on their achievements. This year's winners were:

- Chairman's Award - James Jupp, Consultant Gastroenterologist
- Innovation Award - Ambulatory Care Team
- Leadership Award - Stefanie Thomas, Matron
- Lifetime Achievement Award - John Thorne, BMS, Clinical Pathology
- Patient Choice Award - Agnes Graja, Diabetes Nurse Specialist
- Patient Safety Award - Infection Prevention and Control Team
- Student/Apprentice of the Year Award - Abbie Roster, Recruitment
- Team of the Year Award - Emergency Department (ED)
- Volunteer Award - Peter and Heather Foster

In early 2018 we replaced the WOW! Award scheme, a national employee recognition scheme external to the NHS with our own Hospital Heroes Scheme. We believe in delivering outstanding care for people in ways which matter to them. This is achieved through our commitment to the Trust's Values of teamwork, respect, integrity and excellence. To help honour our Hospital Heroes, we encourage patients, carers, family member and colleagues to thank both teams and individual members of staff who have provided outstanding care to patients. All Hospital Hero Thank You's are published on the staff intranet page and the best nominations will be honoured during a monthly ceremony with a member of the executive team.

Volunteering

The Trust is about to embark on an exciting two year project in association with the Pears Foundation. The project will be focusing on expanding the current volunteering model in line with the Trust's strategic mission to "be at the heart of improving the wellbeing of our communities. Part of this will include developing role descriptions and training requirements for specific areas and monitoring how these roles directly impact on the patient experience. We will also be setting up and maintaining an effective centralised service for support, oversight and ongoing training of volunteers.

The Trust employs a part-time Volunteer Workforce Co-ordinator, Louisa Plant, who regularly visits departments interested in support from volunteers to enhance the service they provide. She also lends assistance to teams setting up new roles and provides follow-on support to staff members designated as volunteer leads for individual wards and departments. In addition to this resource we will be employing a full-time Volunteer Co-ordinator initially on a two year fixed term basis to manage the project. With this increased resource we are looking to develop a strategy to improve the retention of our volunteers and how we celebrate the contribution they make.

Some of the key roles we are looking to introduce are Dementia Buddies, Mealtime Assistants, Home from Hospital Assistants/Discharge Assistants and Befrienders/Companions. Obviously as well as establishing this period of change we will still be championing our longstanding volunteering roles such as the Hospital Guides, Friends of DCH, Ridgeway Radio and the Chaplaincy Service. Potential volunteers considering joining the Trust can contact Louisa via louisa.plant@dchft.nhs.uk.

Education, Learning and Development

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

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

Preceptorship
We continue to run The Preceptorship Programme with two intakes a year; we had a large intake of 29 Preceptees in September 2017 across several areas including, Adult Nursing, Therapies, Midwifery, ODP and Radiology. In February 2018 we had a smaller intake of nine with Adult Nurses, Paramedics and therapies, we have offered places for September 2018 and offer bespoke programmes to overseas nurses.

Apprenticeships
In 2017/18 we saw 39 apprenticeship sign-ups across many areas in the Trust including Nursing, Medical, Radiology, Support Services, Administration, Education and Management; this includes five foundation degrees in health which are proving to give positive results. 34 existing staff began apprenticeship courses and seven new apprenticeship positions were filled. New apprenticeship roles are being planned with the introduction of the higher apprenticeships being released during 18/19. The Trust are working with the Dorset Wide Apprenticeship Group for procurement of providers for all apprenticeship courses. The Care Certificate continues to achieve 98 – 100% completion with the set targets and leads directly into the apprenticeship standards for health care, a more concise version had been devised to meet the needs of existing staff who wish to progress onto to further training.

Bridging Programme
The Bridging Programme has continued for 2017/18 with eight Healthcare Support Workers undertaking the course which will help them towards their progression onto Adult Nursing training. We offer free Maths and English Functional Skills courses for all staff and had 17 staff gaining Level 1/ 2 qualifications which helps them progress in their work and progress to further study.

General Medical Council (GMC) Visit
February 2018 saw the GMC Quality Assurance Visit to Dorset County Hospital, this is part of the wider Health Education England – Wessex Quality Visit. The visit consisted of an initial collation of education governance documentation which was mapped against the GMC standards for Education and Training. In February 2018 the GMC visiting team came to the Trust and met a range of staff including executives, medical students, trainee doctors and consultants. The overriding feedback was positive with all staff that were interviewed by the GMC stating they would recommend this Trust as a place to work and train. There were some outstanding actions which are being managed by the divisions. There will be a final presentation of the overarching outcome for Health Education England – Wessex in September 2018.

Leadership Development
The Leadership Development programme continued in 2017/18 with further Leadership Engagement sessions for our senior leaders and a programme of modules for our team leaders and aspiring leaders.

More than 400 staff in supervisory or team leader roles attended a range of modules on core leadership skills including effective leadership, Personal resilience, coaching skills, difficult conversations and Service improvement. The modules were very well attended and received.

A leadership strategy, vision and objectives has been developed to ensure our workforce is empowered with the skills to deliver safe, effective and compassionate care and inspire a culture of continuous learning and innovation to support improvement in quality, safety and efficiency. This will form part of the revised People Strategy.

The Leadership Development pathway has been reviewed and refreshed. A key part of the programme is the use of leadership style awareness tools in order to inform and guide the learner in there development. Implementation of the refreshed programme has already commenced and will be fully operational by September 2018.

The process of enhancing and formalising our talent management programme got underway during 2017 with a review of the senior roles within the organisation to ascertain any key workforce challenges and succession planning required.

Library

Trust staff and students on placement benefit from the professional library service which offers access to a wide range of print and electronic information resources and expert library staff. The service belongs to the large Thames Valley and Wessex NHS library network.

Consultancy

The NHS has additional controls for spending on consultancy contracts over the value of £50,000 to ensure value for money. The Trust had no contracts which exceeded the £50,000 limit. The table below shows the consultancy costs breakdown by category. These figures include £71k of costs linked to the local Vanguard project with Poole and Bournemouth.

	2017/18 £000s
Finance	15
Human Resources	55
Procurement	21
Property and Construction	18
Strategy	247
Information Technology	11
Technical	11
Total	**378**

Reporting High Paid Off-payroll Arrangements

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

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

For any off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months	Number of engagements
Number of existing engagements as of 31 March 2018	Nil

The Trust can confirm that we had no existing off-payroll engagements that had lasted for longer than six months as of the 31 March 2018.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months	Number of engagements
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	2
Of which…	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	1

No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	Nil
No. of engagements reassessed for consistency/assurance purposes during the year.	Nil
No of engagements that saw a change to IR35 status following the consistency review	Nil

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	Nil
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	15

The Trust has made no payments for off payroll arrangements to individuals through their own companies during 2017/18.

The following sections of the Staff Report are subject to audit

Average number of employees (WTE basis)

	Average for year ended 31 March 2018		
	Total number	Permanent number	Other number
Medical and dental	328	321	7
Administration and estates	384	384	-
Healthcare assistants and other support staff	767	763	4
Nursing, midwifery and health visiting staff	681	660	21
Nursing, midwifery and health visiting learners	4	3	1
Scientific, therapeutic and technical staff	216	215	1
Healthcare science staff	74	74	-
Social care and staff	2	-	2
Other	1	1	-
Total	2,457	2,421	36
Of which: Engaged on capital projects	10	10	-

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

Employee Expenses

	Total £000	Permanent employed £000	Other total £000
Salaries and Wages	89,029	88,051	978
Social security costs	8,309	8,309	-
Apprenticeship levy	426	426	-
Pension cost – NHS pensions	10,729	10,729	-
Pension cost – other	10	10	-
Termination benefits	82	82	-
Temporary staff – Agency/contract staff	3,005	-	3,005
Total Gross Staff Costs	**111,590**	**107,607**	**3,983**
Included within; costs capitalised as part of assets	457	417	40

Exit Packages

2017/18 Exit package cost band	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
< £10,000	-	12	12
£10,001 - £25,000	-	2	2
£25,001 - £50,000	1	-	1
Total number of exit packages by type	1	14	15
Total resource cost (£000)	26	56	82

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

The payments included in 'Other departures' agreed for 2017/18 are in respect of contractual payments made in lieu of notice (2016/17 Fourteen payments for lieu of notice). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in this table.

Disclosures Set Out in the NHS Foundation Trust Code of Governance

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

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

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

Board of Directors

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

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

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

- Director of Strategy and Business Development

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

The Trust has made the following appointments to the Board during 2017/18:

- One Non-Executive Director who commenced on 1 November 2017.

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

To Board has the following key functions:

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

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

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

The Trust has in place a formal annual appraisal process for both Executive and Non-Executive Directors carried out against agreed objectives. The Chief Executive appraises other Executive Directors, the Chair appraises the Chief Executive and Non-Executive Directors. The appraisal of the Chair is led by the Senior Independent Director. The outcomes of Executive Directors' appraisals are shared with the Remuneration and Terms of Service Committee, and those of the Chair and Non-Executive Directors with the Nominations and Remuneration Committee.

Board of Directors' Profiles

Chair
Mark Addison – first term 24/3/2016 – 23/3/2019
Mark has had an executive career in central government, working in senior operational and policy roles in a number of departments. He was the Chief Executive of the Crown Prosecution Service, Director General for Operations in the Department of Environment, Food and Rural Affairs, and was for a short spell the permanent Secretary of that Department and Chief Executive of the Rural Payments Agency. He has previously held non-executive roles, sitting on the boards of The National Archives and the Which? Council. He was the Chair of the Nursing and Midwifery Council. Mark remains a Public Appointments Assessor and a member of the Advisory Committee on Business appointments. These commitments have no impact upon his ability to chair Dorset County Hospital NHS Foundation Trust.

Chief Executive

Patricia Miller – appointed substantive Chief Executive 15 September 2014

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

Non-Executive Directors

Peter Greensmith – first term 1/6/14 – 31/05/17. Vice Chair from 1/10/16 second term – 1/6/17 – 31/5/20

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

Matthew Rose – first term 17/6/14 – 16/6/17 second term 17/6/17 – 16/6/20

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

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

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

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

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

Sue Atkinson - first term 1/09/16 – 31/8/19
Sue has considerable experience in Public Health, clinical medicine, commissioning, as a chief executive, executive director and non-executive director in the NHS and DoH. She was Regional Director of Public Health (RDPH) for London and developed the role as Health Advisor to the Mayor and Greater London Authority. She was previously RDPH and Medical Director of South Thames, South West Region and Wessex. Her work includes health strategy, inequalities and partnership working, including with national and local government and the third sector. Sue holds a number of non-executive and academic posts, including founding Director and Chair of PHAST (Public Health Action Support Team – a not for profit social enterprise). She is a Board Member of the Faculty of Public Health, Visiting Professor at UCL, Co-Chairs the Climate and Health Council and was a board member of the Food Standards Agency.

Ian Metcalfe - first term 1/11/17 – 30/10/20
Ian is an experienced Finance Director and a qualified management accountant who started his career in the commercial sector, but for the past twenty years has worked as an executive and non-executive director in the not-for-profit, charity and health sectors, and more recently in arts organisations. Ian has served on a number of Boards, including eight years as a non-executive director with Royal Bournemouth Hospital, where he was Chair of a number of committees, including the project board which led the re-build of Christchurch Hospital as a health and care community. He is currently a trustee of Lighthouse, Poole's centre for the arts, and has just rejoined the Board of Activate, an arts enabling organisation based in Dorchester.

Non- Executive Directors who left during 2017/18

Graeme Stanley – first term 1/10/13 – 30/9/16, second term 1/10/16 – 30/9/19. Senior Independent Director
Graeme is a former Chief Executive of a South West based housing group. He is currently working in consultancy acting as Aster Group's Strategy and Implementation Director and is Chairman of Bracknell Forest Homes, Non-Executive Director Forest Future homes Ltd and Non-Executive Director MB Crocker Ltd. He is a fellow of the Chartered Institute of Housing and holds an MSc in Strategic Management and Housing. Graeme's previous non-executive roles include non-Executive Director of the Independent Housing Ombudsman.

Executive Directors

Chief Operating Officer: Julie Pearce – appointed 26 May 2015
Julie joined the Trust in May 2015 from East Kent Hospitals University Foundation Trust where she held a combined role of Chief Nurse and Chief Operating Officer. Julie is a first level Registered Nurse with specialist qualification in critical care nursing and holds BSc and MSc in Nursing Studies. She has worked in a number of acute teaching hospitals in Leeds, London, Birmingham, Cardiff and Southampton before becoming the nursing advisor for acute and specialist services at the Department of Health. In 2004 Julie took up her first Director post as Chief Nurse for Hampshire and Isle of Wight Strategic Health Authority and then moved to East Kent Hospitals in 2007. Julie's passions are the provision of person-centred, high quality services through continuous service improvement and innovation. She has a good track record in leading and developing clinical services across a network of acute and community hospitals.

Director of Finance and Resources: Libby Walters – appointed 12 September 2012
Libby came to the Trust in September 2012 from Yeovil District hospital NHS Foundation Trust where she was Director of Finance and Deputy Chief Executive. Libby has worked in the NHS for 22 years and has a track record of ensuring strong financial performance. She has a particular interest in ensuring the focus on use of resources is intrinsically linked with improving the quality of care provided.

Medical Director: Paul Lear – appointed 1 October 2011 – retired in March 2018
Paul qualified from London University in 1975. Following further periods of training in the Midlands and in Boston, USA, he was appointed to his first consultant position in 1988, at London's St Bartholomew's Hospital. In 1991, Paul moved to Bristol to practise as a specialist vascular and renal transplant surgeon, from where he has also worked closely with the renal service at Dorchester. Paul was the inaugural clinical Director of surgery and the then newly merged Frenchay and Southmead Hospitals (now North Bristol Trust) and maintained this role for 10 years.

Director of Nursing and Quality: Nicky Lucey – appointed 1 September 2016
Nicky joined the Trust from Kent Community Health NHS Foundation Trust where she was Director of Nursing and Quality. During her career Nicky has held a number of senior roles, including director of clinical standards at Portsmouth Hospitals NHS Trust. Her wealth of experience includes having successfully led many initiatives, such as workforce redesign involving education and career development, as well as patient care improvements. Nicky, who trained at Uxbridge, Middlesex, also has an MBA from Solent University. She has a professional background in cardiothoracic and critical care.

Director of Organisational Development and Workforce: Mark Warner – appointed 2 March 2015
Mark formerly worked for Buchinghamshire Healthcare NHS Trust from July 2013 and was responsible for leading the people agenda for the Trust. Previously, he was Head of Human Resources at West Sussex County Council. Mark has more than 25 years' experience in the field of HR, including 18 years in the airline industry with British Airways.

Director of Strategy and Business Development: Nick Johnson – appointed 1 February 2016 (non-voting)
Nick joined the Trust from University Hospital Southampton NHS Foundation Trust where he was responsible for strategy and commercial development projects, including establishing and innovative commercial development joint venture, for which he was a Board Member. Prior to that, he was responsible for business development and bid management at a large, multi-national infrastructure and support services provider focusing on strategic public private partnerships. Nick has also worked in a number of local authorities delivering innovative strategic partnerships, contract management and service transformation. Nick has an MSc from Warwick Business School and started his career on the National Graduate Management Scheme for Local Government.

Attendance at Trust Board Meetings 2017/18

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

P – Present
A – Apologies
N – Not applicable

Council of Governors

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

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

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

The Council of Governors meets on a quarterly basis.

Attendance at Council of Governor Meetings 2017/18 (4 regular quarterly meetings) Members and Constituency		Current Tenure	Attendance at Council of Governors
ELECTED GOVERNORS			
David Cove (Lead Governor)	West Dorset	01/06/17 - 31/05/20	4/4
Christine Case	West Dorset	10/07/15 – 09/07/18	3/4
Les Fry	West Dorset	10/07/15 – 09/07/18	2/4
David Tett	West Dorset	10/07/15 – 09/07/18	3/4
Gavin Maxwell	West Dorset	01/06/17 - 31/05/20	3/3
Andy Hutchings	Weymouth and Portland	10/07/15 – 09/07/18	4/4
Sharon Waight	Weymouth and Portland	10/07/15 – 09/07/18	1/4
Dave Stebbing	Weymouth and Portland	01/06/17 - 31/05/20	3/3
Margaret Alsop	Weymouth and Portland	01/06/17 - 31/05/20	2/3
Christine McGee	North Dorset	10/07/15 – 09/07/18	3/4
Simon Bishop	East Dorset, Christchurch, Poole and Bournemouth	01/06/17 - 31/05/20	3/3
1 VACANCY	East Dorset, Christchurch, Poole and Bournemouth		
1 VACANCY	North Dorset		
1 VACANCY	West Dorset		
1 VACANCY	Weymouth and Portland		
1 VACANCY	South Somerset		
STAFF GOVERNORS			
Ron Martin	Staff	10/07/15 – 09/07/18	1/4
Tracy Glen	Staff	01/06/17 - 31/05/20	3/3
Lee Armstrong	Staff	01/06/17 - 31/05/20	3/3
Tony James	Staff	01/06/17 - 31/05/20	2/3

APPOINTED GOVERNORS (the Trust has two unfilled appointed Governors)			
Peter Wood	Age UK		4/4
Jenny Bubb	Dorset Clinical Commissioning Group		4/4
Keith Brookes	Dorset County Council		3/3
Annette Kent/Barbara Purnell	Friends of DCH		1/4
Paul Bithell	Dorset Kidney Fund		1/4
Davina Smith	Weldmar Hospicecare Trust		3/4
GOVERNORS WHO LEFT DURING THE YEAR			
Michel Hooper-Immins	Weymouth and Portland	10/07/15 - 20/02/18	3/3
Jane Holdaway	West Dorset	10/07/15 – 31/05/18	1/1
Edward Gibbs	Weymouth and Portland	01/06/13 - 31/05/17	0/1
Peter Coghlan	East Dorset, Christchurch, Poole and Bournemouth	01/06/13 - 31/05/17	1/1
Duncan Farquhar-Thomson	Staff (Lead Governor)	01/06/13 – 31/05/17	1/1
Piet Bakker	Staff	01/06/13 – 31/05/17	1/1
Ian Gardiner	Dorset County Council		1/1

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

Governor elections took place during 2017/18 which were administered by UK Engage. Elections took place in the following constituencies:

- West Dorset
- Weymouth and Portland
- East Dorset, Christchurch, Poole and Bournemouth
- Staff
- North Dorset
- South Somerset/Rest of England

Further details are contained in the table above.

During 2017/18 the Council of Governors maintained three committees to progress various aspects of the Council's work:

- Nominations and Remuneration Committee – to develop and deliver the selection and recruitment process for new Non-Executive Directors
- Membership Development Committee – to implement the Membership Strategy and develop communication and engagement mechanisms with the membership
- Constitution Review Committee - to review the Trust's Constitution to ensure it meets current Statutory and Local and National governance requirements.

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

Nominations and Remuneration Committee

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

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

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

The Nominations and Remuneration Committee convened four times during the period. The meetings took place on 2 May, 26 May, 3 July and 16 November.

Nominations and Remuneration Committee	Number of meetings attended
Mark Addison – Chair	4/4
Peter Greensmith – NED/Vice Chair	1/4
Michel Hooper-Immins – Public Governor	4/4
Andy Hutchings – Public Governor	4/4
Christine McGee – Public Governor	4/4
David Tett – Public Governor	3/4
Peter Wood – Appointed Governor	2/4
Duncan Farquhar-Thomson – Staff Governor/Lead Governor	1/3
David Cove – Lead Governor	1/1
Lee Armstrong – Staff Governor	1/1

How the Board and Governors Work Together

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

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

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

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

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

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

Director Attendance at Public Council of Governors' Meetings during 2017/18

Name	Title	Attendance/ Meetings eligible to attend
Mr Mark Addison	Chair	4/4
Mr Peter Greensmith	Vice Chair	2/4
Mr Graeme Stanley	Non-Executive Director	1/4
Mr Matthew Rose	Non-Executive Director	0/4
Ms Victoria Hodges	Non-Executive Director	0/4
Ms Judy Gillow	Non-Executive Director	0/4
Prof Sue Atkinson	Non-Executive Director	1/4
Mr Ian Metcalfe	Non-Executive Director	0/2
Ms Patricia Miller	Chief Executive	4/4
Ms Libby Walters	Director of Finance and Resources	1/4
Mr Paul Lear	Medical Director	0/4
Ms Julie Pearce	Chief Operating Officer	0/4
Mr Mark Warner	Director of OD and Workforce	2/4
Ms Nicky Lucey	Director of Nursing and Quality	3/4
Mr Nick Johnson	Director of Strategy and Business Development	4/4

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

Membership of the Trust

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

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

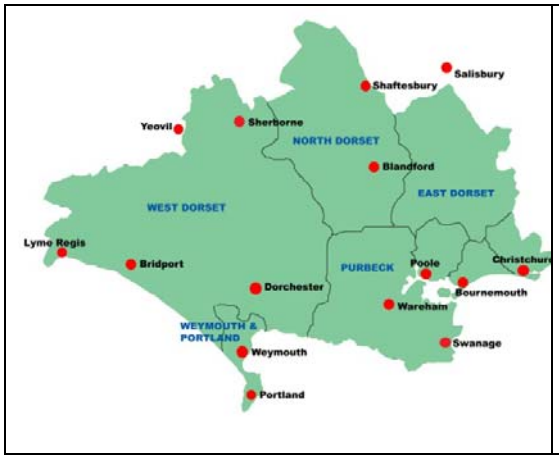
Membership is open to people ages 16+ years who live in one of the Trust's public constituencies. Registration as a member can be via a membership application form from hospital reception areas, online at www.dchft.nhs.uk, via email to foundation@dchft.nhs.uk, or by phoning 01305 255419.

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

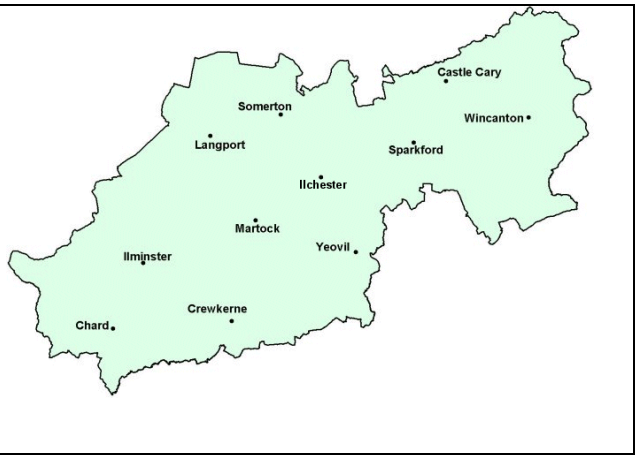
The Trust has maintained a fairly steady level of membership throughout 2016/17 despite efforts by Governors and staff. It is felt that the elderly demographic may contribute to the challenges in recruitment.

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

Dorset



South Somerset



Constituency	2017/18	2016/17
West Dorset	1,284	1,476
Weymouth and Portland	758	874
North Dorset	268	323
South Somerset and out of area	100	87
Purbeck, East Dorset, Christchurch, Poole and Bournemouth	240	268
Total Public Constituencies	2,650	3,028
Staff	3,507	3,396
Total	6,157	6,424

Auditors

The Trust's audit services from 1 April 2017 to 31 March 2018 were provided as follows:

- Internal Auditors – KPMG – the internal audit plan is risk based and is developed annually in conjunction with Executive Directors. The draft plan is then agreed by the Audit Committee. The plan comprises both financial and clinical quality audit work, in addition to reviews of areas which are considered by Executive Directors and/or Internal Audit to be high risk or of concern.

- External Auditors – BDO – external auditors prepare and present an annual plan of work to review the financial management and reporting systems of the Trust and provide assurance that the annual accounts and supporting financial systems are operating effectively. Should external auditors be asked to provide non audit services, this has to be in line with the Trust's policy on Engagement of External auditors for Non-Audit Services.

Audit Committee
The Audit Committee provides assurance to the board on the effectiveness of the Trust's systems of governance and control across the full range of the Trust's responsibilities. It does this by receiving and testing assurance provided in relation to the establishment and maintenance of effective systems of governance, risk management, finance, counter fraud and internal controls and assures itself regarding the Trust's compliance with regulatory, legal and other requirements. The Audit Committee's remit encompasses healthcare assurance as well as the more traditional audit areas of finance and corporate governance.
Internal Audit assists the Audit Committee by providing clear statements of assurance regarding the adequacy and effectiveness of internal control. The Director of Finance and Resources is professionally responsible for implementing systems of internal financial control and is able to advise the Audit Committee on such matters.

At its meetings on 22 May 2018 the Audit Committee considered the financial statements and agreed that they contained no significant issues that required addressing under the terms of the UK Corporate Governance Code 2014, para C3.8.

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

Arrangements for allowing staff to raise concerns are detailed in the Trust's Whistleblowing Policy which was reviewed during 2017/18 by the Partnership Forum.

Audit Committee Attendance

Name	Title	Attendance/ Meetings eligible to attend
Mr Graeme Stanley	Audit Committee Chair	4/4
Mr Matthew Rose	Non-Executive Director	7/7
Prof Sue Atkinson	Non-Executive Director	7/7
Ian Metcalfe	Non-Executive Director and Committee Chair from November 2017	3/3

Single Oversight Framework

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

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

Based on information from these theses, providers are segmented from 1 to 4, where "4" reflects providers receiving the most support, and "1" reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

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

Segmentation

NHS Improvement has placed the Trust in Segment 2 as at 31st March 2018. Segment 2 is Providers offered targeted support.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from "1" to "4", where "1" reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017/18 scores				2016/17 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial Sustainability	Capital service capacity	1	4	4	4	2	2
	Liquidity	3	4	3	3	2	2
Financial Efficiency	I&E margin	2	4	4	4	3	4
Financial Controls	Distance from financial plan	1	1	1	1	1	2
	Agency spend	1	1	1	1	2	2
Overall Scoring		2	3	3	3	2	3

Sustainability Report

Introduction

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

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

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

2017/18 has been a challenging year for the Trust. There were periods of extreme weather such as the hot weather in June 2017 when air conditioning was in high demand and the periods of cold weather and snow in March 2018 when the heating was in constant use.

The Trust is based in a countryside location and has a high number of vehicles entering the site. For many staff, patients and visitors, their home locations mean driving is their only option when attending the Trust. The Trust acknowledges this as an issue and has trialled outpatient clinics in local community hospitals nearer to patient's home addresses. The Trust has entered discussions with the County Council to investigate ways of improving public transport accessibility to the Trust.

A key project that will help the Trust reduce its carbon contribution is the replacement of plant equipment through the Carbon Energy Fund (CEF). The CEF is an organisation that facilitates energy infrastructure upgrades, including funding mechanisms, legal and technical advice. The Estates Department has worked diligently throughout 2017/18 to ensure the Trust will obtain guaranteed energy and financial savings with minimal capital investment. The Trust signed a contract with a provider to deliver infrastructure improvements throughout 2018/19. This will involve replacing original boilers with modern and efficient units, installing new combined heat and power systems to recycle excess heat, and to replace approximately 60% of light fittings across the hospital with LED units. These measures will lead to an estimated 30% carbon emission savings, whilst providing more resilient energy infrastructure.

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

Energy Use

Figures 1 - 4 show a summary of energy consumption and associated CO_2 emissions for the period 2012/13 to 2017/18. For the purposes of NHS and HM Treasury reporting, energy consumption is shown in gigajoules (GJ) and kilowatt-hours (kWh). Please note February and March 2018 figures are estimates based on usage in February and March 2017 due to data being unavailable at the time of writing.

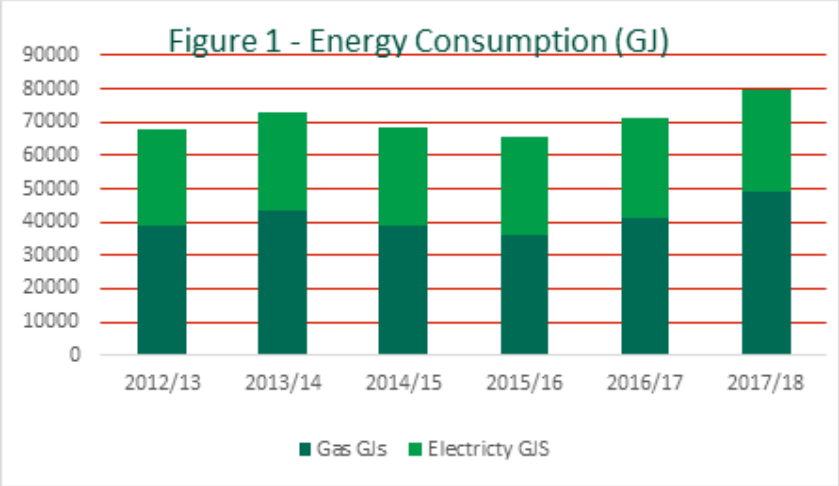


Figure 1 - Gas consumption increased from 41,204 GJ in 2016/17 to 48,940 GJ in 2017/18, a 18.77% increase. Electricity consumption increased from 30,142 in 2016/17 to 30,789 GJ 2017/18, a 2.1% increase.

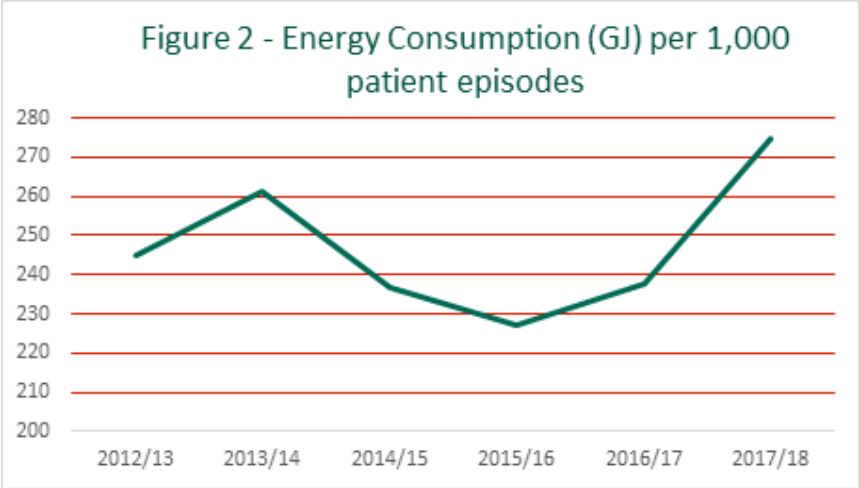


Figure 2 - energy consumption per 1,000 patient episodes increased from 237.82 GJ in 2016/17 to 274.93 GJ in 2017/18, a 15.6% increase.

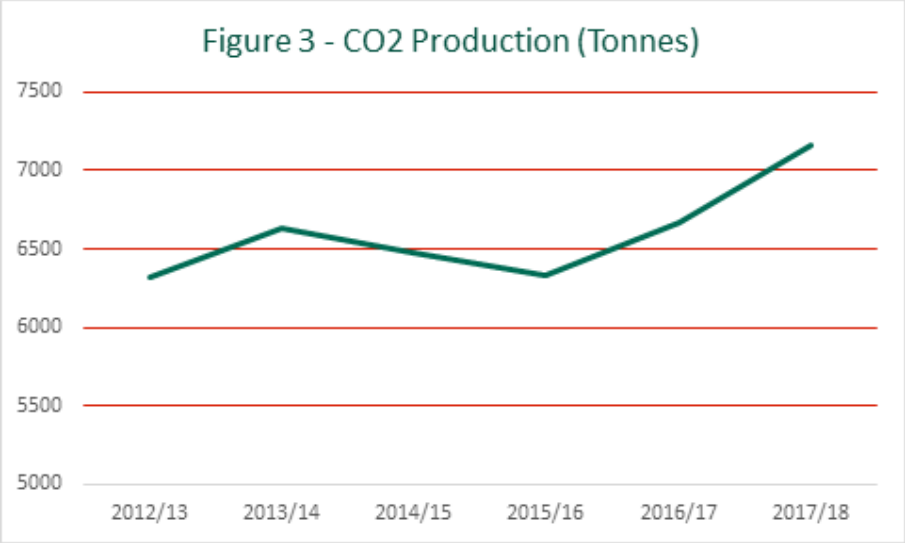


Figure 3 - CO_2 production increased by 495 tonnes during the year 2017/18 to 7,160 tonnes. This is an increase of 7.5%.

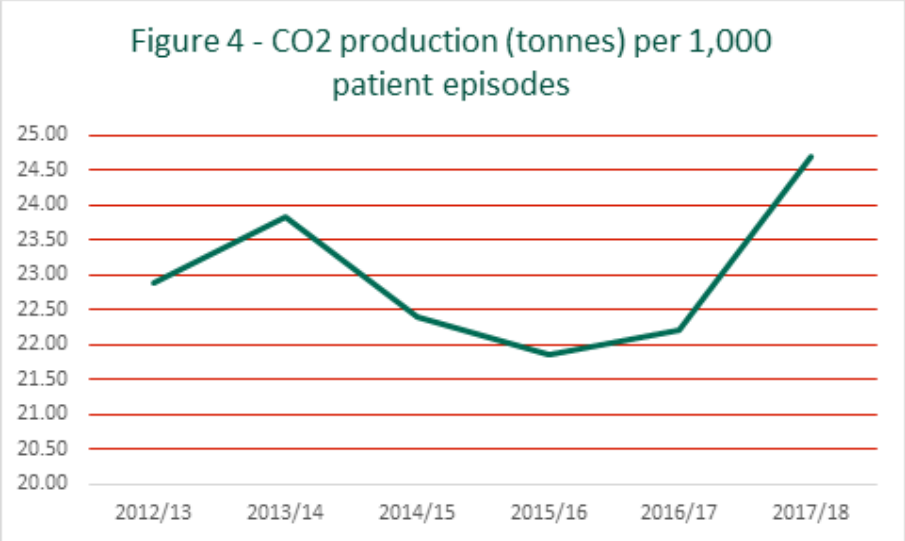


Figure 4 - CO_2 production per 1,000 patient episodes increased from 22.22 in 2016/17, to 24.69 in 2017/18. This is an increase of 11.1%.

The upward trends in energy use can be attributed to new estate being created and a long and challenging winter. Additional building footprint includes a new commercial coffee shop, the acquisition and partial occupation of the former Damers School, and ongoing construction work creating a new radiotherapy and outpatients building.

The Trust has implemented a number of initiatives to channel energy consumption improvements including:

- Accurate monitoring of energy and use of real data over assumptions
- LED light fittings are installed whenever a fitting needs adding or replacing

- Continued promotion of energy conservation through a sustainability day, inclusion in the induction programme for new starters, and regular promotional events

Water Use

Figures 5 and 6 provide a summary of water consumption during the period 2012/13 to 2017/18. Consumption is shown in cubic metres (M^3). Please note February and March 2018 figures are estimates based on usage in February and March 2017 due to data being unavailable at the time of writing.

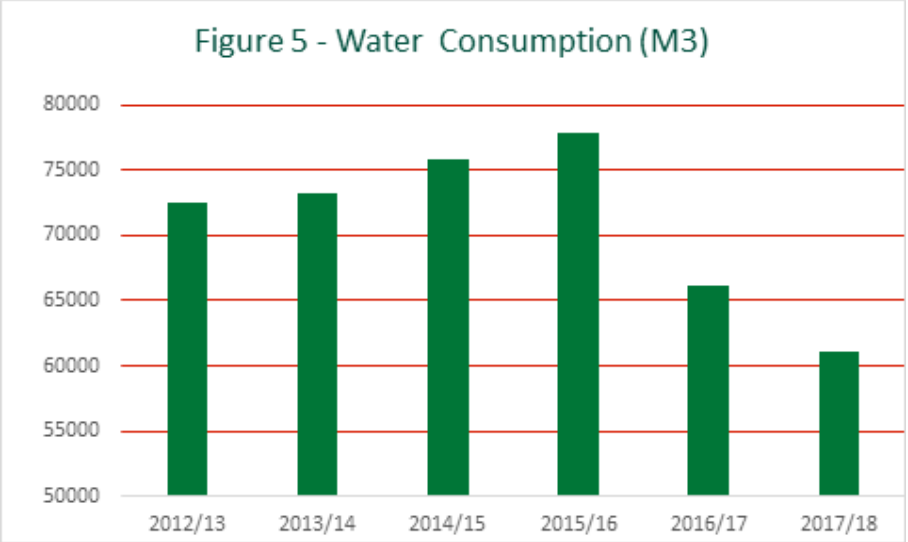


Figure 5 - water consumption fell from 66,206 M^3 in 2016/17 to 61,158 M^3 in 2017/18. This is a 7.6% reduction.

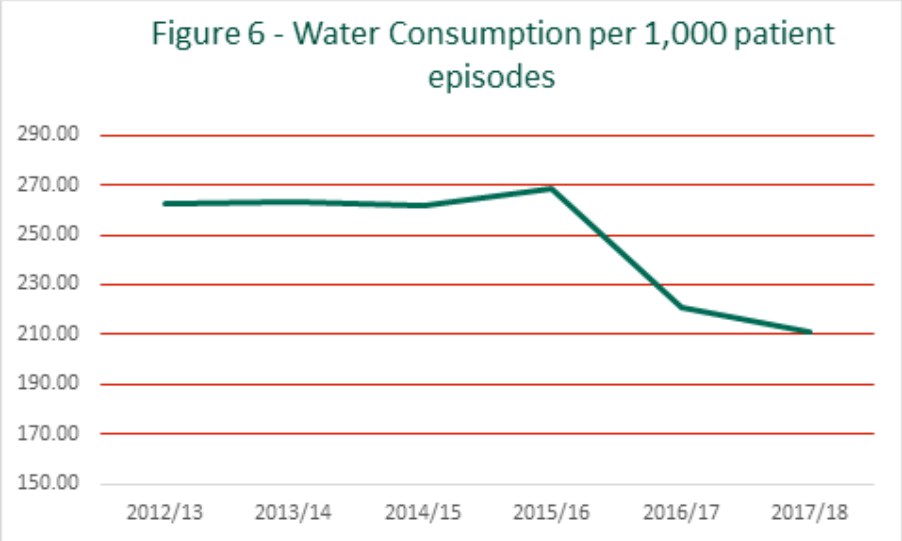


Figure 6 – water consumption per 1,000 patient episodes fell from 220.69 M^3 in 2016/17 to 210.89 M^3 in 2017/18. This is a 4.44% reduction.

The Trust remains committed to reducing water consumption. The Trust is performing significantly better than in 2012-2015.

Water efficiency measures implemented during 2017/18 include:

- Educating staff about water usage in their induction
- More intelligent outlet flushing as part of the water hygiene process
- Priority given to resolve water leaks throughout the estate – unfortunately these have become more prevalent throughout 2017/18 due to aging infrastructure

Waste

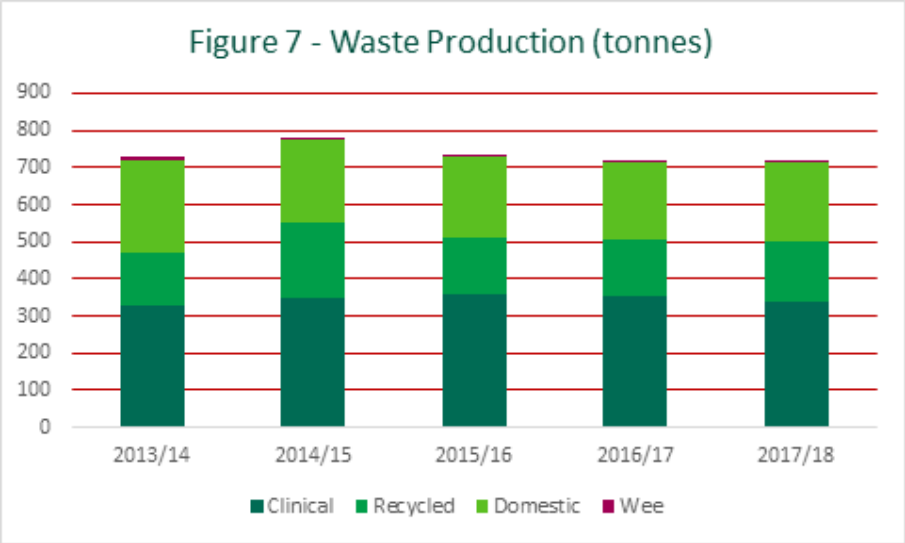


Figure 7 - Overall waste production for 2017/18 stood at 721.13 tonnes compared to 717.1 tonnes in 2016/17. This shows a 0.6% increase.

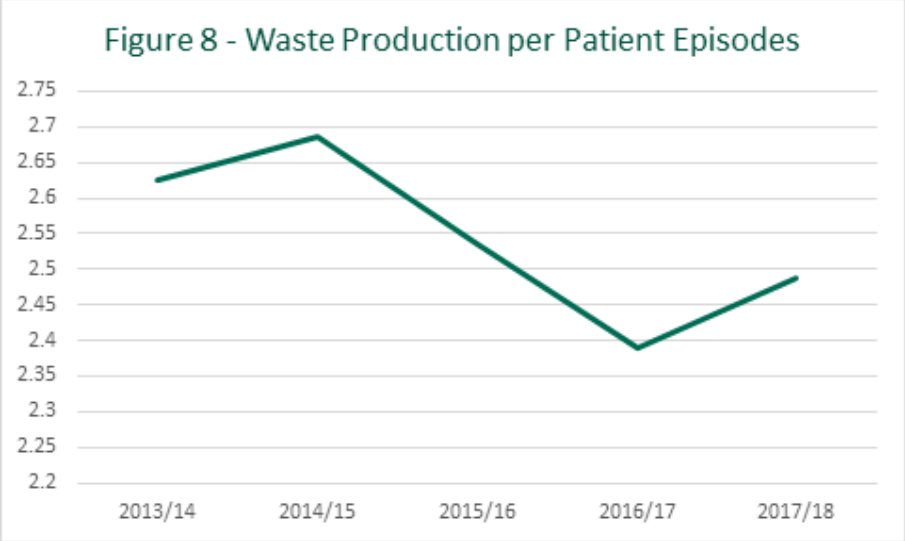


Figure 8 - waste production per patient episode increase from 2.40kg in 2016/17 to 2.48kg in 2017/18. This is a 3.3% increase. Of the total waste produced, 22.08% was recycled matching the 2016/17 figure of 22%.

The Trust remains committed to reducing waste. Waste reduction measures implemented during 2017/18 include:

- Encouraging recycling with the introduction of hot drink cup refill discount.
- Use of local suppliers, obtaining greater than 51% or fresh produce from suppliers / farmers within the south west reducing waste from travel
- Continued roll out of recycling bins throughout the site

Fugitive Emissions

The Trust has a robust contracted maintenance regime in place to minimise Fluorinated Gas losses. Gas top ups are recorded to indicate where losses may have occurred. Gas losses in 2017/18 are attributed to natural seepage in line with equipment design.

Procurement

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

- Whole life cycle training for key procurement staff.
- Robust inventory management including working towards Scan for Safety accreditation.
- Ensuring key contracts contain sustainability criteria.
- Continued use of sustainable products (e.g. FSC wood).
- Introduction of quality assurance and sustainable and ethical standards in the procurement of food items.

Transport

Total business mileage during 2017/18 was 967,308 miles, a reduction of 20.08% over the 2016/17 figure of 1,210,274. The reduced miles can be attributed to the more efficient booking systems being in place to ensure greater use of pool cars over employee's own vehicles and the use of pool cars being encouraged.

The cost of business mileage fell by 12.1%, helped by lower fuel prices and pool car models being replaced with more carbon efficient models.

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

- Introduction of a cycle shelter for patients with clear access to hospital main entrance
- The continual assessment and review of transport needs via travel surveys
- Promotion of sustainable transport measures to all staff
- Regular joint meetings with Dorset County Council and local transport companies to promote the use of sustainable transport such as membership of First Bus Corporate Travel Club

Building and Refurbishment

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

Notable building projects that have had sustainability implications throughout 2017/18 include:

- A collaboration with Poole NHS Hospital Trust to construct a Radiotherapy centre and oncology outpatient's area. This will be operational in late summer 2018 and enable patients to travel shorter distances for radiotherapy treatment.

- The acquisition of approximately 4.5 acres of land adjacent to the hospital that was occupied by Damers School. This land was purchased in 2007 with handover in April 2017 when the school relocated to new energy efficient premises in Poundbury. Although the site has increased the Trust's energy consumption, it is being used as a catalyst for some wider estates master planning.

- The cardiac catheter lab was refurbished, including the addition of an air handling unit to replace a non-compliant air conditioning system. Although an air handling unit consumes more energy, it ensures the required number of air changes are obtained in the procedure space and contributes positively to infection prevention.

- The aging and poorly functioning air conditioning in the coronary care unit and high dependency unit was replaced with a new system. The new system is approximately 15% more energy efficient, has added resilience if there is a hardware failure, and enhances infection prevention.

Sustainable Development Management Plan (SDMP)

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

The SDMP targets are:

1. **Energy and Carbon Management**

- Reduce energy consumption to 38 kwh per patient episode by 2020.

- Reduce energy consumption from buildings by 34% by 2020 (based on 2007 levels)

Both targets will be supported by the implementation of plant machinery upgrades via the Carbon Energy Fund. This work will be delivered throughout 2018/19 and will reduce the Trusts carbon emissions by at least 30%.

2. **Low Carbon Travel, Transport and Access**

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

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

Sustainable travel options are being developed and liaison with Dorset County Council and the Dorset NHS Clinical Commissioning Group is ongoing around this.

3. Water

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

More work is to be completed on outlet flushing for Legionella prevention to further minimise water use. For example, more accurate monitoring of water outlets that are not flushed in each period through natural use but may not require dedicated flushing every time.

4. Waste

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

This year the Trust has commenced the removal small desk bins in office environments and replaced these with larger centralised recycle and general waste bins. This increases recycling rates by providing a choice at the point of disposal.

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

5. Designing the Built Environment

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

Limitations on capital budgets meant that all schemes in 2017/18 were under £2 million. Despite this, building projects have adopted some BREEAM principles, particularly around lifecycle energy use and cost considerations.

6. Organisational Workforce Development

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

A sustainability intranet page is now available to all staff via the intranet. Engagement with staff has increased with sustainability days held in Damers restaurant and electronic surveys undertaken around areas such as transport and parking.

7. Role of Partnerships and Networks

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

Partnership working has improved with stakeholders and other trusts. This is expected to continue to improve as joint working within the NHS increases. Strategic estates master planning has led the Trust to discuss areas of sustainability with key stakeholders, particularly around transport and travel. These stakeholders have included Dorset County Council, West Dorset District Council, Dorchester Town Council, and the Duchy of Cornwall.

8. Governance

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

Tasks are reviewed in regular Sustainability and Travel Working Group meetings.

9. Finance, Procurement and Food

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

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

Data

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

Table 1

Energy consumption	2013/14	2014/15	2015/16	2016/17	2017/18
Gas (1,000 GJ)	43.7	38.9	36.1	41.2	48.9
Electricity (1,000 GJ)	29.1	29.7	29.7	30.1	30.8
Total Energy (1,000 GJ)	72.8	68.6	65.8	71.3	79.7
Gas (1,000 kWh)	12,092.5	10,769.1	9,999.3	11,414.0	13,556.9
Electricity (1,000 kWh)	12,165.3	10,837.6	10,065.1	11,485.3	8,528.9
Total Energy (1,000 kWh)	24,257.8	21,606.7	20,064.4	22,899.3	22,085.8

Table 2

Energy consumption and emissions per patient episode	2013/14	2014/15	2015/16	2016/17	2017/18
Total Energy (1,000 kWh)	24,257.8	21,606.7	20,064.4	22,899.3	22,085.8
CO2 Emissions (100 tonnes)	66.3	64.8	63.4	66.7	71.6
Patient episodes (1,000's)	278.4	289.4	293.6	300.0	290.0
kWh per patient episode	87.1	74.7	68.3	76.3	76.2
CO2 Emissions per patient episode (kg)	23.8	22.4	21.6	22.2	21.8

Table 3

Energy financial indicators	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000
Energy expenditure	1,201.1	1,279.1	1,280.5	1,278.3	1,289.1
Carbon reduction commitment expenditure	76.4	102.2	96.5	95.7	110.2

Table 4

Water use & costs	2013/14	2014/15	2015/16	2016/17	2017/18
Water use (1,000m3)	73.2	75.8	77.8	66.2	61.2
Patient episodes (1,000's)	278.4	289.4	293.6	300.0	290.0
Water use per patient episode (litres)	262.9	261.9	265.0	220.7	210.9
Water and sewerage expenditure (1,000's)	235.2	262	215.2	176.1	190.3

Table 5

Waste production	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
High temp clinical waste (tonnes)	47	49.6	42.8	41	37.48
Alternative treatment clinical waste (tonnes)	279	297.2	314.9	310.2	302.61
Total clinical waste (tonnes)	326	346.8	357.7	351.2	340.09
Domestic waste (tonnes)	252	222.3	216	208.2	215.55
WEEE (tonnes)	10.2	4.2	7.9	1.2	6.3
Recycling (tonnes)	143	204	153	156.5	159.21
Total waste (tonnes)	731.2	777.3	734.6	717.1	709.3
% of waste recycled (including WEEE)	20%	26%	21%	22%	22%

Table 6

Waste costs	2013/14 £'000	2013/14 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000
High temp clinical waste	28.56	28.76	27.51	13.56	20.77
Alternative treatment clinical waste	148.12	142.52	113.57	133.61	132.91
Total clinical waste	176.68	171.28	141.08	147.17	153.68
Domestic waste	42.52	31.26	39.78	33.43	8.5*
WEEE	0.32	0.69	1.34	0.31	4.00
Total waste costs	219.52	203.23	182.20	180.91	166.18

*Black bag waster costs not available

Table 7

Business travel and costs	2013/14	2014/15	2015/16	2016/17	2017/18
Business mileage (miles)	1,113,840	956,562	970,440	1,210,274	967,308
Total expenditure on business travel (£)	498,563	484,394	462,199	414,108	364,160

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Dorset County Hospital NHS Foundation Trust.

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

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

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

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

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

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

Patricia Miller
Chief Executive
22 May 2018

Annual Governance Statement

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Dorset County Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

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

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

- identifying sources of potential risk and proactively assessing risk situations, and mitigating those risks as far as possible;
- identifying risk issues through the reporting of serious untoward incidents, adverse incidents, near misses, complaints and claims, and internal and external review reports;
- investigating and analysing the root causes of risk events;
- undertaking aggregated root cause analysis (considering risk events, complaints, claims and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) data);
- taking action to eliminate or at least minimise harmful risks;
- monitoring the delivery and effectiveness of actions taken to control risk;
- learning from near misses, risk events, legal claims and complaints and sharing the lessons learned across the organisation

- RCAs are reviewed at a 'Learning from Incidents' Panel which is chaired by the Medical Director and the Director of Nursing, which enables a positive challenge to the staff regarding the root cause, the learning and helps to identify any notable practice.

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

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

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

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

The Risk and Control Framework

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

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

The Trust's Risk Event Reporting Policy requires staff to report all adverse incidents, both actual and potential (near misses), and sets out the methodology and responsibilities for assessing and

evaluating the risks. The impact of a risk will dictate at which level of the organisation the risk event is investigated and reported, with the lowest category (green) managed at a local level and the highest (red) managed at executive level with reports made to the Board and statutory external agencies.

During the first part of 2017/18, the Trust's main risks related to ophthalmology service capacity, financial sustainability and access to care in the community.

The Trust provides an Ophthalmology service which covers a large geographical area. This service covers a range of monitoring and interventions for a number of eye conditions, including glaucoma, cataracts and AMD. Demand placed on the service has previously exceeded capacity resulting in delays to outpatient and elective care. The Ophthalmology service went through a significant period of change in 2016/17 and there were more changes during 2017/18. The service is working on improving the skill mix of staff with practitioners roles and community Optometrists to assist with the Paediatric work. Looking forward to 18/19 the service will be looking to improving efficiency in outpatients and reduce waiting times for follow-up appointments.

Financial Sustainability
The lack of access to care in the community increases the number of delayed transfers of care experienced by the Trust. The work with partner organisations has progressed significantly during 2017/18, but is yet to realise a notable reduction in delays.
For 18/19 both financial sustainability and the Ophthalmology service remain key risks for the Trust. The Trust is also beginning to report risks in respect of medical staffing (ENT, Emergency Department and Gastroenterology).

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

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

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

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

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

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

- **Information Assurance:** The Data Quality Management Group has provided a robust mechanism to monitor and control data quality measures for the clinical Information Systems. This group has been re-formed into an Information Assurance Group that will extend data quality assurance to cover all aspects of data quality within the Trust including the data items reported on the Trust dashboards.

- **Governance.** Governance improvements around the Information Assurance Group have been made in order to allow other Groups such as the Clinical Coding Task and Finish Group and the Clinical Informatics Group to escalate all data quality issues to Information Assurance Group. Finally, bi- monthly highlight reports to Health Informatics Programme Board will provide appropriate visibility on any major data quality issues.

- **Information Dashboards.** The performance dashboards have been reviewed frequently and appropriate improvements have been implemented. **Ownership.** Improving ownership of data quality issues is a long term objective of the information strategy. The Information Assurance Group with its new governance structure ensure ownership and responsibilities are agreed, supported at executive level and cascaded down through divisional directors and managers who will hold staff accountable. The two Divisional Information Analysts will be expected to work closely with the senior divisional management and clinical teams to identify and resolve any data quality issues that might arise.

- **Regular audit and external assurance**. Audits and in-depth analysis of data quality are conducted in a number of areas, including: mortality; specialist clinical coding areas (on a regular, randomly selected basis as per national best practice recommendations); in additional to departmental clinical audits. Key issues will be discussed at the Information Assurance Group to ensure a culture of continuous improvement on data quality.

- **Information Systems**. As more information is captured in our information systems and business processes change accordingly, it is important to understand the data quality implications from any systems change. The Information Assurance Group has been working closely with the system managers and the key business users to address any data quality issues.

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

The Trust was rated as 'good' for four services overall: children and young people, medical care, surgery and critical care. Four services were rated as 'requires improvement': urgent and emergency services, maternity and gynaecology, end of life care and outpatients. In total, inspectors found 25 out of the 39 factors they assessed 'good' – 64%. Overall the Trust was rated overall as 'requires improvement'. The Trust anticipates a further inspection in 2018/19.

The Trust implemented its new organisational structure and governance framework from 1 April 2017 (two Divisions with their own leadership and governance structure). An external Well-Led review was commissioned and action plan developed in November 2017 with oversight from the Board.

The Trust is able to assure itself of the validity of its Corporate Governance statement as required under NHS Foundation Trust Licence condition 4 through the following mechanisms that have been deployed during 2017/18:

- the Board has maintained a strong emphasis on quality in its meeting agendas to ensure that quality is the focus of decision making and planning;
- the Board has an executive lead for quality and clear accountability structures are in place for a quality agenda that is integrated into all aspects of the organisation's work;
- the Board carries out visits to wards to meet with staff and patients and gain feedback. The governors also carry out assurance visits;
- the Board has driven and overseen delivery of the 2017/18 Operational Plan, demonstrating that the Trust can operate with efficiency, economy and effectiveness;
- the Board has maintained appropriate oversight of regulatory and inspection regimes including that of NHS Improvement, the Care Quality Commission and the Health Research Authority and has monitored the management of gaps where any have been identified. The Board encourages close working with regulators and inspectors to ensure that all requirements are met and quality standards are maintained the highest level;

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

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

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

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

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

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

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

The Trust produces detailed annual plans reflecting its service and operational requirements and its financial targets in respect of income and expenditure and capital investments. The plan incorporates the Trust's plan for improving productivity and efficiency in order to minimise income losses, meet the national efficiency targets applied to all NHS providers and fund local investment proposals. Financial plans are approved by the Board, having been previously assessed by the Finance and Performance Committee.

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

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

Information Governance

The Trust operates under the Guidelines and Legislation which govern Information Governance within the NHS and have embedded the processes necessary to meet the standards required and have submitted an Information Governance Toolkit score of 87%. Our Information Risk Management Policy and Risk Management Structure is owned by the Trust's Senior Information Risk Owner and reviewed via the Information Governance Committee, alongside Information Asset Assurance Reports from the Trust's Information Asset Owners and a rolling overview of all Information Security and Information Governance incidents at each bi-monthly meeting. The Trust's Information Risk Policy sit's hand in hand with the Trust's Information Security Policy which details the security arrangements in place for systems and devices.

The Trust reported three serious incidents during the 2017/2018 but none to the Office of the Information Commissioner. The first incident related to the wrongly labelled blister pack being given to the wrong patient; the incident was quickly identified and blister pack retrieved. The second incident involved a member of staff leaving a folder containing identifiable information in a ward area. A member of staff retrieved the folder but there was potential for a patient or member of the public to access. The third incident involved potentially identifiable staff information being released in response to a Freedom of Information request. All staff were notified and procedures strengthened in respect of interim staff.

The Trust has complied with and responded to the 10 Steps Cyber Security return and will be complaint with the new General Data Protection Regulations which come into force in May 2018.

Quality Account

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

The Trust's Quality Accounts priorities for each year are selected following consultation with the Board, Council of Governors, clinicians and other relevant parties. Priorities that will require implementation over a period of years are carried forward into the following year. The Director of Nursing and Quality is the executive lead for the Quality Accounts and preparation of the Quality

Report. The Trust's policies, procedures and clinical guidelines provide a robust foundation for and support the delivery of quality care. All policies, procedures and guidelines are stored on databases that are centrally co-ordinated to ensure the documents are kept up to date and only current versions are available to staff.

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

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

The Quality Report for 2017/18 is subject to External Audit.

Review of Effectiveness

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

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

The governance structure is a follows:

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

Risk and Audit Committee: Provides assurance to the Board as to the effectiveness of the Trust's systems of governance and control across the full range of the Trust's responsibilities. It reviewed the establishment and maintenance of an effective system of integrated governance, risk management, finance, counter fraud, security management, and internal control across the whole of the organisation's activities, both clinical and non-clinical. It utilises the assurance framework, risk

register, internal and external audit reports, the work of the Quality Committee and the ability to question the Chief Executive regarding the Annual Governance Statement to support its work.

Finance and Performance Committee: Provides assurance to the board and does not remove the requirement for the Board to monitor financial, operational and workforce performance. The Committee provides scrutiny and makes recommendations to the Board to assist in decision making. Specific areas scrutinise by the Finance and Performance Committee include financial planning, operational performance, workforce, business case assessments and the delivery of efficiency and cost improvement programmes. The Finance and Performance Committee is able to approve business cases within delegated limits.

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

My view is further informed by:

- Opinions and reports by Internal Audit, who work to a risk based annual plan. The Head of Internal Audit Opinion for 2017/18 was as follows:

  'Significant with minor improvements' assurance can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

- Opinion and reports from the Trust's External Auditors
- Monthly reports to NHS Improvement
- Full compliance with the Care Quality Commission essential standard for quality and safety for all regulated activities across all locations
- Results of patient and staff surveys
- Investigation reports and action plans following serious incidents
- Council of Governors Assessment Team Reports
- Clinical audit reports

Conclusion
No significant internal control issues have been identified for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Patricia Miller
Chief Executive
22 May 2018

The Accountability Report was approved by the Board of Directors on 22 May 2018 and signed on its behalf by

Patricia Miller
Chief Executive
22 May 2018

Quality Report

Part 1 – Quality Accounts and Approach to Quality

What is a Quality Account?

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

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

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

Dorset County Hospital (DCH) has delivered significant amounts of change to improve both the effectiveness and the quality of its services during 2017/18.

The following report does not reflect the additional improvement's that have been made, but does report on the nine Quality account priorities that were selected for inclusion in 2017/18.
This report covers the period of April 2017 – March 2018

- There has been a significant reduction (27%) in the total number of Hospital falls resulting in severe harm or death
- There has been an improvement in Sepsis screening, although this has not reached the standard required. This remains a quality account priority for the forthcoming year.
- Timeliness of complaint responses continues to cause concern. A remedial action plan has been developed in conjunction with the divisions. This remains as a quality account priority for 2017/18.
- The nine Quality Account priorities have been selected (and previously agreed by the Quality Committee) for the forthcoming year 2018/19. The decision to continue with the quality account priorities selected for the previous year was based on the fact that the Trust still believes that further improvements in these areas can be made. They are detailed within the report.
- The local indicator for inclusion by the governors has been selected as the 'Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' indicator.

Our Approach to Quality

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

In 2017, the Trust reviewed and restructured its governance processes which has provided more structured visibility of quality and safety metrics from 'Ward to Board'.

The Quality Account priorities 2018/19 have been selected by the Trust. These build on the recommendations detailed within the independent reviews as well as reflecting the National and Local commissioning needs and the top risks to quality identified internally.

Statement on Quality from the Chief Executive

The vision for Dorset County Hospital NHS Foundation Trust (The Trust) is to provide '*outstanding care for people in ways which matter to them*'. This means the delivery of excellent clinical outcomes and experiences for our patients and their relatives in a caring, compassionate and safe environment. This Quality Report (also known as the Quality Account) demonstrates the progress made in our quality priority areas in the previous year.

Achievements in 2017/18 include an overall reduction in the amount of patients who sustain severe harm from a hospital fall, improved rates of screening patients for suspected sepsis, implementation of schemes to improve the health and wellbeing of staff, and the successful application for support to launch a 'volunteer strategy'. These are the things that you told us were important to you and the full details of progress are shown in the following sections of this account.

Whilst we recognise the improvements that we have made in the previous year, we still believe that there are further achievements that we can make in these areas to enhance our services. It is for this reason that we, as a Trust, have decided to maintain the same quality account priorities for 2017/18 in the forthcoming year. By doing this we believe that we will be able to maintain the focus on these important areas, ensure that improvements have been sustained and spread and to enable us to then celebrate our successes across other teams within the Trust.

It gives me great pleasure to be able to introduce the Quality Account for the Trust. I am pleased to confirm that that the Board of Directors has reviewed the 2017/18 Quality Account and confirm that it is an accurate and fair reflection of our performance. We hope that this account will provide you with a clear summary of the work that has taken place in the previous year to improve the services that we provide, and our commitment to make further improvements where required

As the Chief Executive Officer for the Trust, I would also like to personally thank all of the staff for their dedication and commitment. This is demonstrated and observed on a daily basis, and without this, the Trust would not be able to deliver the outstanding care that it provides. I would also like to thank our patients and their relatives for sharing their experiences with us. Without this valuable information we would not be able to focus on the things that matter most to you, and most importantly, we would not be able to deliver the improvements that we do.

To the best of my knowledge the information in the document is accurate.

Patricia Miller
Chief Executive
22 May 2018

Part 2 – Our Quality Priorities

Priorities for Improvement 2017-2018

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

Last year, we set our priorities:

Patient Safety:

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

Clinical Effectiveness:

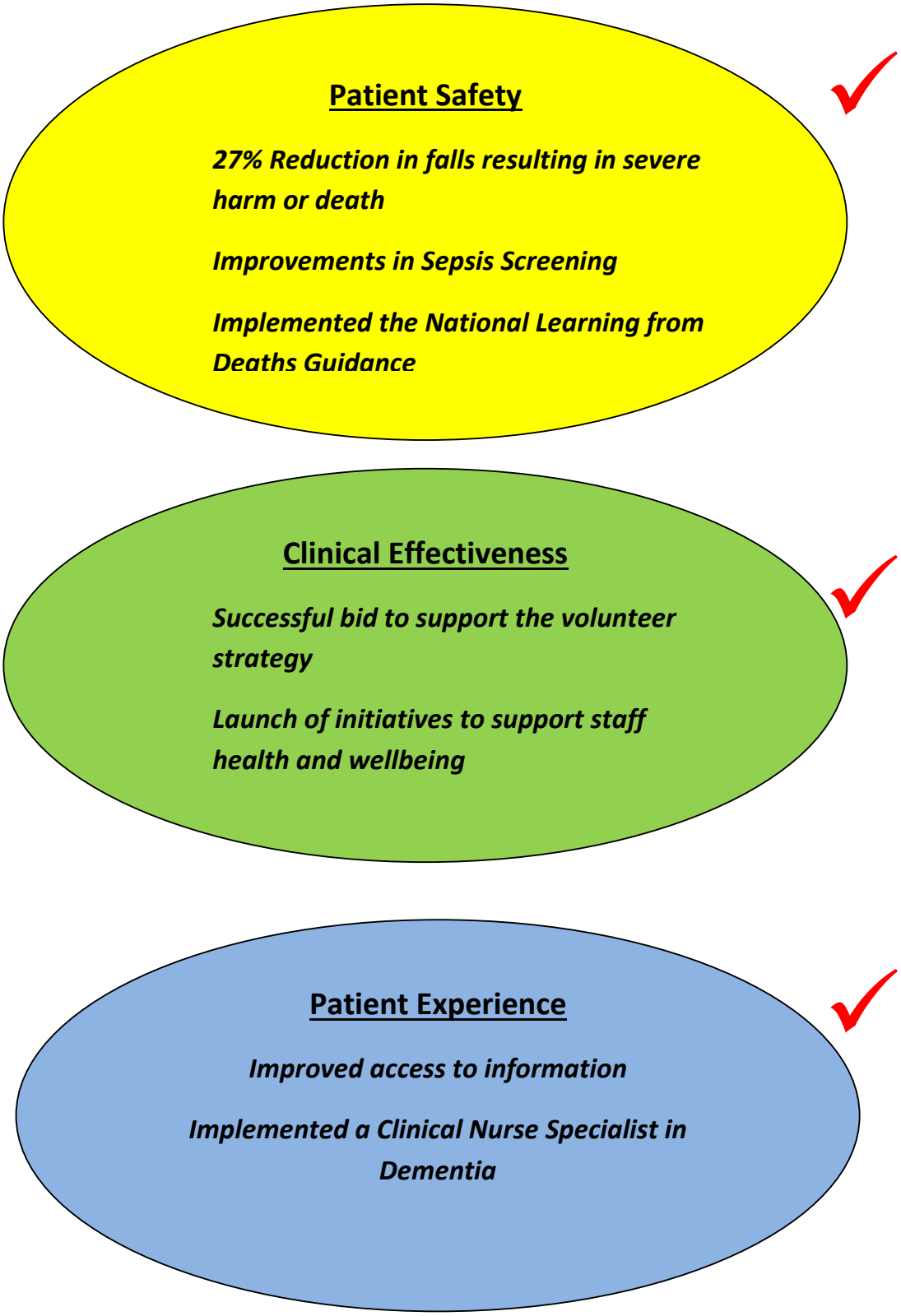
- Improving the support from Hospital Volunteers to have positive effects on clinical outcomes (Loneliness Agenda)
- Increasing the percentage of Electronic Discharge Summaries (EDS) sent within 24 hours
- Promoting the Health and well-being of both patients and staff

Patient Experience:

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

These priorities are reported on section three of this report.

Quality Achievements 2017/18



Priorities for Improvement 2018/19

Although the Trust has delivered many improvements throughout 2017/18 in relation to the nine quality account priorities set for that year, it is the view of the staff and of the governors that there is more that can be achieved in relation to these priorities.

The Trust has, therefore, agreed the continuation of the quality priorities set for 2017/18 into 2018/19 to allow for more robust monitoring and to evaluate the improvements observed over a longer time frame.

The Trust Board has set the following priorities for 2018/19:

Patient Safety

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

Clinical Effectiveness

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

Patient Experience

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

The Board will monitor progress against these priorities by receiving regular reports from management throughout the year and reporting performance in our reports that are made available publically and to the Trust's stakeholders.

Statement of Assurance from the Board

1. During 2017 – 2018, The Trust provided and/or subcontracted 35 relevant health services.

1.1 The Trust has reviewed the data available to them on the quality of care in all of these relevant services.

1.2. The income generated by the relevant health services reviewed in 2017 – 2018 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2017 – 2018.

2. During 2017 - 2018 45 clinical audits and 5 national confidential enquiries covered relevant health services that the Trust provides.

2.1 During that period the Trust participated in 96% National Clinical Audits and 100% National Confidential Enquiries which it was eligible to participate in.

2.2 The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in during 2017- 2018 are as follows:

2.3 The National Clinical Audits and National Confidential Enquiries that the Trust participated in during 2017- 2018 are as follows:

2.4 The National Clinical Audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2017- 2018, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits

The NHS England-funded National Clinical Audit and Patient Outcomes Programme (NCAPOP) are a mandatory part of NHS contracts, and as such we are required to participate in those that relate to services provided by this Trust. The following table describes the audits we have participated in, and the relevant compliance. * Please note that in some cases the % of Registered Cases is above 100%; this is because the trust was able to identify additional cases than those identified by the HES (Hospital Episode Statistics) data

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	121	100%
Adult Bronchiectasis	Y	Y	11	100%
Bowel Cancer (NBOCAP)	Y	Y	Figures pending	%
Cardiac Rhythm Management (CRM)	Y	Y	407	100%
Case Mix Programme (CMP)	Y	Y	765	100%

ICNARC					
Child Health Clinical Outcome Review Programme		Y	Y	Figures pending	%
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		Y	Y	111	100%
Diabetes (Paediatric) (NPDA)		Y	Y	94	100%
Elective Surgery (National PROMs Programme)		Y	Y	2017-18 data released August 2018	
Endocrine and Thyroid National Audit		Y	Y	53	100%
Falls and Fragility Fractures Audit programme (FFFAP)	Hip Fracture Database	Y	Y	281/281	100%
	Fracture Liaison Service	Y	Y	1807	100%
	Falls	Y	Y	31	100%
Head and Neck Cancer Audit		Y	Y	PGH	PGH
Inflammatory Bowel Disease (IBD) programme		Y	Y	Biologics – 95(229contacts in total)	100%
Learning Disability Mortality Review Programme (LeDeR Programme)		Y	Y	6 *review outcomes not yet available	100%
Major Trauma Audit (TARN)		Y	Y	226	95%
Maternal, Newborn and Infant Clinical Outcome Review Programme		Y	Y	4	100%
National Maternity and Perinatal **Audit** (**NMPA**)		Y	Y	1871	100%
National Cardiac Arrest Audit (NCAA)		Y	Y	102	100%
National (COPD) Pulmonary Rehabilitation Audit		Y	Y	26	100%
COPD - Secondary Care (Continuous data collection)				284/335	85%

National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery		Y	Y	2	100%
National Diabetes Audit - Adults		Y	Y	3917	100%
National Diabetes In-Patient Audit (NaDia) 2016		Y	Y	54	100%
National Diabetes Foot Care Audit**		Y	Y	61	100%
National Diabetes in Pregnancy Audit		Y	Y	13	100%
National Emergency Laparotomy Audit (NELA)		Y	Y	120/120	100%
National Heart Failure Audit		Y	Y	216	100%
National Joint Registry (NJR)	Hips	Y	Y	458/430	106%
	Knees			340/306	111%
	Shoulders			34/31	109%
	Elbows			0/1	%
	Ankles			1/0	%
National Lung Cancer Audit (NLCA)		Y	Y	140	100%
National Ophthalmology Audit**		Y	Y	0/1692	0%
National Prostate Cancer Audit		Y	Y	Figures pending	%
National Vascular Registry	AAA	Y	Y	4	100%
	IIB			38	100%
	Amputation			78	100%
Neonatal Intensive and Special Care (NNAP)		Y	Y	247	100%
Nephrectomy audit		Y	Y	Published figures relate to regional caseload and include Private Practice	
Oesophago-gastric Cancer (NAOGC)		Y	Y	Figures pending	%
Percutaneous Nephrolithotomy (PCNL)		Y	Y	Published figures relate to regional caseload and include Private	

			Practice	
Radical Prostatectomy Audit	Y	Y	Published figures relate to regional caseload and include Private Practice	
Renal Replacement Therapy (Renal Registry) (figures for 2016 pending)	Y	Y	Figures pending	%
Sentinel Stroke National Audit programme (SSNAP)	Y	Y	395	100%
Pain In Children (RCEM)			59/50	118%
Procedural Sedation in Adults (Care in ED) (RCEM)			50/50	100%
Fractured Neck of Femur (RCEM)			50/50	100%
UK Cystic Fibrosis Registry	Y	Y	Figures pending	
*Stress Urinary Incontinence Audit	Y	N	0	0

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

National Confidential Enquiries into Patient Outcome and Death (NCEPOD)

NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. * Please note that in some cases the Trust may have been eligible, but 0 cases were submitted; this is because no eligible cases were identified during the period required.

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% of Registered Cases
Chronic Neurodisability*	Y	Y	0	
Young People's Mental Health*	Y	Y	0	
Cancer in Children, Teens and Young Adults	Y	Y	1	100%
Acute Heart Failure	Y	Y	6	100%
Perioperative Diabetes	Y	Y	ongoing	

	This year the reports published are:
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	**National Confidential Inquiry into Suicide and Homicide by People with Mental Illness -** As this relates to ED, most patients are issued with TTA(To Take Away medicines) packs or an FP10 (external prescription), with the latter the prescriber would only prescribe a limited amount for patients at risk of self-harm. The Trust is assured that our current practice is safe.

The reports of 42 National Clinical Audits were reviewed by the provider in 2017-18. The table below summarises the audit outcomes:

Name of audit / Clinical Outcome Review Programme. Report publication date	What this Trust knows
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	This latest report contains figures for April 2015 to March 2016. During this time DCH had very poor data capture and results could not be included in the report. The issue with adequate administrative support has now been resolved and assurance has been recived that data upload will be performed.
BAUS Urology Audits: Cystectomy	The data for these British Association of Urological Surgeons(BAUS) audits are reviewed regularly at the Urology Departmental Clinical Governance Meetings. The reports cover services that run jointly across the Urology Network, including private practice.
BAUS Urology Audits: Nephrectomy	
BAUS Urology Audits: Percutaneous nephrolithotomy	
BAUS Urology Audits: Radical prostatectomy	
BAUS Urology Audits: Urethroplasty	
National Bowel Cancer Audit (NBOCAP)	Data quality was excellent, although a single area (pre-treatment TNM(tumor-node-metasases cancer staging) documentation) can be improved. The current level for this area is 74% (higher than the regional or national level). Rates of laparoscopy were very high for resectional surgery (75%). This is well above the national rate of 61%. Low rates of hospital stay over 5 days were achieved 56% vs 69% national). 90 day mortality, 2 year survival and 30 day readmission rates were within normal limits and similar to network data. DCH has a low rate of 18 month stoma rate.
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Implant rates and physiological pacing percentages continue to be excellent (well below the quoted average rates in the literature). DCH benefits from a combined heart failure and devices lead and weekly multidisciplinary team (MDT) meetings – this means that all devices are considered in severe heart failure patients. Implant rates should improve further still when regular Consultant and nurse (rather than just nurse) follow up clinics are implemented for all severe heart failure patients once on optimal therapy. The new S-ICD (Subcutaneous Implantable Cardioverter Defibrillator) service should also impact on service
Diabetes (Paediatric) (NPDA)	DCH is a positive outlier, exceeding (by some way) the high SD limit for completing all seven care processes in those over 12 (78% receiving this). Our performance is within the top 5% in the country.

Elective Surgery (National PROMs Programme)	DCH continues to participate in this national patient outcome measure's programme for patients undergoing hip, knee and shoulder surgery. The data is collated centrally and then reviewed locally at the Orthopaedic clinical governance meetings
Endocrine and Thyroid National Audit	All local data is within the expected range and no actions are required
Falls and Fragility Fractures Audit programme (FFFAP) National Audit of Inpatient Falls	This was the second National Audit looking at inpatient falls assessments and risk. It did not look particularly at patients who had fallen, rather at those who by nationally defined guidance were at risk of falling. In 2017 we recruited the required number of individuals to the audit. Our results were favourable in all categories compared with national averages (with the exception of measuring lying and standing blood pressure which the trust believes should only be reserved for relevant patients).
National Hip Fracture Database	This report confirms good performance in management of hip fracture at DCH including good time to theatre and time to ward from ED. Our risk adjusted mortality has improved on last year (a higher than average case mix adjusted mortality rate was highlighted in the 2015/16 report). The only area requiring improvement is recording the absence of a pressure ulcer - this was highlighted in HQIP's quality dashboard. Practice has now changed and we now record pressure ulcer status for all patients rather than only those who develop pressure ulcers.
Fracture Liaison Service (FLS)Database	This report summarises data collected in 2016; the FLS team was not up to full compliment until Jan 2017. Despite this, our performance was good for identification and time to FLS assessment; monitoring contact was highlighted as an area for improvement. A local audit was carried out after the FLS team were up to full compliment and shows that we are now performing above national average against all of the national parameters
Inflammatory Bowel Disease (IBD) programme	Our previous challenges with collection and upload of biologics data have been resolved and we contribute to this programme. There have been no inpatient audits within the last few years
Learning Disability Mortality Review Programme (LeDeR)	We are aware of the obligation to report deaths of patients with learning disabilities whilst in our care. Deaths of patients with learning disability are notified to the LD Nurse, who informs the LeDeR programme. This programme is relatively new and we do not yet have any data to review, although 6 cases have been submitted
Major Trauma Audit	DCH continues to continuously upload data to the central database and continues to perform well. The data is sent back to us to allow direct comparison of outcomes with those of similar patients in other units throughout the country. This year DCH was identified as a positive outlier with a better than expected risk-adjusted hospital mortality ration for patients with predicted risk of death <20%
MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)	MBRRACE is the perinatal confidential enquiry into term, singleton intrapartum stillbirths and intrapartum related neonatal deaths. The annual report shows that: 1 .There are some shifts where staffing is below expected level. 2. There is MDT training in place with all staff expected to attend PROMPT training (Practical Obstetric MultiProfessional Tranining), some staff have attended human factors training. 3. All antenatal and intrapartum stillbirths (and unexpected neonatal deaths) are investigated using the RCA format with a multidisciplinary team which includes any parental questions. 4. Currently all staff participate in K2 CTG(cardiotocography – fetal monitoring) training.

	5. National guidance is awaited for a standardized risk assessment tool for women who present in labour with ongoing risk assessment throughout. 6. Currently there is no national guidance for care in the latent phase of labour. 7. All senior midwives who work clinically are NLS trained. There is 24/7 paediatric cover. Recruitment processes are in place and having a good response. DCH are working towards a local risk assessment tool for women who present in labour, and a tool for the latent phase of labour. There are plans to increase skills and drills training on the maternity unit and plans to roll out human factors training. The home birth team are planning to undertake training with specific regard to serious problems in the home environment.
Medical and Surgical Clinical Outcome Review Programme	DCH continue to fulfil the obligations for data entry to this national dataset. There have been no themed reports from this programme this year
iBRA – Immediate Breast Reconstruction Audit	In this voluntary national audit four categories were assessed and the results were compared with 2008 National Mastectomy and Breast Reconstruction Audit (NMBRA) which measured implant loss, infection rates, unplanned readmissions and unplanned reoperations. The overall results nationally found that the major complications are no better than in 2008 with unplanned return to theatre worse than before. These results are considered by the specialty as disappointing and not acceptable. Dorset County Hospital Breast Unit results are based on 28 patients. Our performance was better than the national average in all four parameters. However in all parameters our results are below OPS (Oncoplastic Surgery) Guide to Good Practice guidelines. The team are implementing these standards.
National Audit of Breast Cancer in Older Patients (NABCOP)	This is a new audit; the first report concentrates on organisational structure of breast cancer care for older patients. The recommendations in the report are generic for all Trusts: This is a slightly unusual audit in the respect that it raises awareness of the special needs of elderly cancer patients & encourages teams to provide surgery rather than palliative endocrine treatment
National Audit of Dementia	DCH areas of good compliance are**:** overall governance (with our Dementia Action Group, dementia leads, and champions); assessment of nutrition – this was an area of excellence; discharge planning. Our areas for improvement are: carer and staff communication; documentation of the diagnosis of dementia and functional implications; dementia screening rates; appointment of a Dementia Nurse/specialist .
National Cardiac Arrest Audit (NCAA)	No report received this year
National Chronic Obstructive Pulmonary Disease Audit programme (COPD) Pulmonary Rehabilitation	The service at DCH is close to the national average for initial assessment, with a lower DNA(Did not attend) rate. Our service meets the National Quality Standard 4 by offering twice weekly sessions and the recommended number of exercise sessions. We meet quality standard 8 by offering an initial assessment which includes MRC(medical research council) dyspnoea scale and health status measure. A discharge assessment is completed at the end of the group sessions. The group exercise sessions include aerobic and resistance training and put us among the 98% and 99% national figures for these components respectively.

National Comparative Audit of Blood Transfusion programme *(Numbers too low to allow submission)*	The number submitted to this audit for DCH was below the expected inclusion rate. The report will be reviewed by the Hospital Transfusion Committee for learning points.
National Diabetes Audit - Adults	The report showed that NHS DORSET CCG return rate dropped from 64.3 to 59.6% - there are data collection issues, with HbA1c(plasma glucose concentration) & creatinine returns from DCH being above average, while cholesterol & urine albumin are lower than expected. Many routinely collected data are not present/noted in the data returns. The target achievement is similar between the CCG and DCH (and is also broadly similar to the rest of the UK) There are no areas of concern
National Diabetes in Pregnancy Audit 2016	DCH continues to have good early contact once pregnancy has been detected (7/40), and good compliance with starting folic acid as soon as pregnancy is diagnosed. Overall HbA1c is poorer this year compared to previous years. As numbers included in the audit are small this is subject to large changes and is often beyond the control of DCH. The need remains to increase awareness of preconceptual planning and ensuring good glycaemic control and higher dose folic acid consumption. DCH excelled in having more paired HbA1c readings and show improvement in control through pregnancy.
National Diabetes Footcare Audit	Our data collection was incomplete at 12 & 24 week follow-up; at DCH 24.1% of pts had an unknown outcome at 24 weeks (compared with 12% nationally). Data collection/entry is being strengthened with a plan for closer involvement of the Diabetes admin team. Of concern is that there is a long (approximately 3 week) wait for new referrals to be seen. As evidenced in the national audit, the longer the delay, the more likely that patients have an amputation and the more likely they will need a hospital admission. 65.5% of pts referred to DCH were seen > 14 days after referral. Compared with 28.1% nationally. A business case has been developed.
National Emergency Laparotomy Audit (NELA)	Summary of this year's performance pending
National Heart Failure Audit	Data collection for this audit continues to be difficult, as all patients with heart failure (not just those admitted under the care of cardiology are included). Despite this DCH results are good, performing well in: drug prescribing; echo assessment and cardiology/specialist review. Less than half of those patients were admitted to a cardiology ward.
National Joint Registry (NJR)	Summary requested from specialty
National Lung Cancer Audit (NLCA)	In this reporting period DCH entered data for 115 patients (compared to 99 in the previous audit). Data entry is good - the MDT have worked hard to access real time data and now retrospectively complete any missing data. There is good discussion of cases at MDT. At DCH 67% of patients have a diagnosis (compared to the aspirational standard of >80%), however, this has improved slightly since last year to 67.8%. 87.2% of our patients were seen by a lung cancer nurse specialist (against a recommendation of >90%). This was investigated and was found to be due to annual leave, missed documentation & verbal messages not passed on to CNS.
National Maternity and Perinatal Audit (NMPA)	The audit showed that there was no 'typical' maternity unit which reflected that services were often organised to meet local need. More than four fifths of Trusts were involved in a Maternity network and two thirds in a perinatal mental health network – this is also applicable to DCH.

	As is the case in Dorchester, nearly all Trusts reported as conducting multiprofessional team training for emergency situations involving Mothers and Babies. Community postnatal visits were not universal and many were being planned around the women and their families. Across sites, there was a huge variation in staffing and maternity services as a whole perceived the level of continuity of care as low. It was acknowledged that there are no national standards for midwifery and obstetric staffing.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	DCH performs above the national average for: antenatal steroids; consultation with a senior member of the neonatal team within 24 hours of admission; percentage of babies affected by significant chronic lung disease; screening for retinopathy of prematurity; 2 year follow up assessments. We perform equal to the national average for: admission with temperature within the recommended range; receiving some of mothers milk at the time of discharge. The only parameter where DCH were less than the national average (25% compared to 43%) is magnesium sulphate given to mothers who delivered at less than 30 weeks and this is being addressed.
National Ophthalmology Audit	This audit has been running for 4 years but was only added to NCAPOP(National Clinical Audit and Patient Outcomes Programme) in 2017. Funding for essential software to facilitate the audit has been identified, but the software is not yet available. This is being chased by the Opthalmology team
Oesophago-gastric Cancer (NAOGC)	Summary requested from specialty
Pain in Children	The report for this RCEM(Royal College of Emergency Medicine) audit is not expected until 2018
Procedural Sedation in Adults (care in emergency departments)	The report for this RCEM(Royal College of Emergency Medicine) audit is not expected until 2018
Prostate Cancer	Published in Nov 2017 - Summary requested from specialty
Sentinel Stroke National Audit programme (SSNAP)	Summary requested from specialty
UK Parkinson's Audit	Summary requested from specialty – to be discussed at May team meeting.
Audits from the 2016/17 National Audit Programme where reports were received in 2017/18	
Name of audit / Clinical Outcome Review Programme	**What this Trust knows**
Asthma (paediatric and adults) care in ED (RCEM)	DCH are meeting current RCEM (Royal College of Emergency Medicine) standards regarding the observation, recording & repeating of patient vital signs. DCH are also meeting current RCEM standards regarding the provision of beta 2 agonist nebulisers.
RCEM – Consultant sign off	Although DCH compliance is low for chest and abdominal pain, it was between the median and upper quartile nationally. DCH has lower results for consultant review of unplanned returns; none of the 13 patients included in this audit had consultant review. The reasons for this were explored. Five of these patients (38%) returned in hours when a Consultant was not present and the rest were reviewed by a Specialty Doctor (acceptable local practice but not recognised in this audit).
Severe Sepsis and Shock	Lower results are attributable to the data entry rather than lower

care in ED (RCEM)	performance. The data upload did not include the time correctly. ED will move forward with quarterly local compliance audits (based on CQUIN Sepsis datasets).
UK Cystic Fibrosis Registry	Latest report for 2016. Summary requested from specialty
National Audit of Inpatient Falls	There is a high (and rising), but not yet universally prevalent, use of organisational features to provide accountability for falls prevention activities and reflection on the rates of falls. The Falls Steering Group is working to encorporate FallsSafe into practice.
National Vascular Registry	This audit is no longer relevant to DCH as major vascular surgery is now carried out in Bournemouth (as part of the vascular network)
We do not participate in the following audits as we do not provide this service:	
Adult Cardiac Surgery Congenital Heart Disease Head and Neck Cancer Audit (Poole enter this data) Mental Health Clinical Outcome Review Programme National Neurosurgery Audit Programme Paediatric Intensive Care Prescribing Observatory for Mental Health Specialist rehabilitation for patients with complex needs Stress Urinary Incontinence (provided by Gynae not Urology) National Audit of Intermediate Care (NAIC) National Audit of Psychosis National Bariatric Surgery Registry (NBSR)	

The reports of 161 number local clinical audits were reviewed by the provider in 2017 – 2018. A selection of these is catalogued below, and the Trust intends to take the following actions to improve the quality of healthcare provided:

Local Clinical Audits

Local audits are carried out by the specialties in relation to areas of their work. These may be re-audits of past work, new services, audits relating to risk or service evaluations. 223 local audits were registered during 2017-18 and work will continue to see these through to completion.

Name of Audit	Finding	Outcome
4087 – Re-audit of 3401(May 2015): Reasons for delayed discharged after inpatient angiogram	The aim of the audit was to see if there are any areas for improvement in time to discharge for patients having inpatient angiograms 41% of patients were discharged the same day 73% of patients were discharged within 24 hours	Continued improvement to the PCI lab to allow increasing number of lists Further research in to whether care needs and administration are the cause of the delayed discharge. Continued review of patients by senior doctors after angiograms, and highlighting which patients are suitable for discharge Continued improvement in the TTO system for improvement in delivery time for the discharge medications. Re-audit later in 2018
4086 - Time from admission to angiogram for cardiac chest pain patients; a re-audit of the NSTEMI (Non-**ST**-elevation myocardial infarction) hospital pathway	This audit found: 59% of patients had their angiogram within 60 hours; 89% of patients were seen by cardiology within 24 hours of admission; 97% of patients were seen by cardiology within 24 hours of referral; 92% of angiogram forms were received by the office within 4 hours of decision being made; 81% of patients were moved to a cardiology bed within 24 hours of angiogram decision being made	As a result of this audit: a referral form will be made available on ICE for angiograms; referrals will be accepted via ICE or an email; there will be continued review by the chest pain specialist nurse of all potential angiogram patients, to allow swift clinical prioritisation; there will be continued liaison between the clinical staff and the ward staff, to allow patients to be brought across to a cardiology bed
4099 - Monitoring of staphylococcus aureus (MSSA) on haemodialysis patients	This service review assessed the introduction of an MSSA treatment record on the management of haemodialysis patients screening positive for MSSA. A guidance sheet given to MSSA positive patients has empowered these patients in management of their own care	The renal team are exploring how ICE can be adapted to speed up notification of positive MSSA results
3404 – An audit of GP referrals for Chronic Kidney Disease(CKD), before and after introduction of NICE CKD guidance (2014)	The number of referrals for CKD increased from 488 in 2012 to 574 in 2016. This represents an 18% increase in referrals. Fewer Stage 5 patients (late referrals) are being referred. Blood pressure is improved on referral and more patients have had their cholesterol measured. There is a tendency for more obese patients with CKD. Unfortunately, smoking cessation and pre-referral ultrasound acquisition have not	This audit informs the renal team in service planning, with the introduction of smoking cessation advice

	improved	
4021 - A re-audit to explore whether pain is recognised and adequately treated on Elderly Care Wards (initial audit Oct 2015)	There has been a significant improvement in staff being able to recognise the non-verbal signs of pain in patients which leads to improvements of analgesia delivery to patients in pain. However it is thought the standards are still not being met in all areas. This could lead to delayed rehabilitation, increased length of stay and increased patient distress.	As a result of this audit the physio team will: develop an education board focusing on non-verbal signs of pain and the abbey pain scale, to be displayed on both Day Lewis and Barnes ward; encourage the use of abbey pain scale on elderly care wards, therapists will begin to document the pain scale in written notes and use the abbey pain scale in MDT's/Board rounds; provide one to one training.
4017 - How well do we meet the physiotherapy standards for critical care?	This audit found that 65% of patients admitted to critical care had their rehabilitation needs assessed within 24 hours. Those not assessed were due to factors such as the patient being too unstable or requiring other investigations or procedures. 57% of patients of suitable patients received rehabilitation for a minimum of 45minutes, for a minimum of 5 days a week.	Patients now have a CPAx score recorded. A re-audit is planned in six months when there is greater clarity of who needs comprehensive assessment and rehabilitation.
3976 - Evaluating completion of the 'Achieving priorities of care of the dying person' in clinical practice	This audit found that: the majority of care plans are being completed by the palliative care team; the palliative care team are completing the plans more thoroughly than doctors and nurses; the 'Plan & Do' sections of the care plan (in particular questions regarding holistic patient care) are poorly completed; we are consistently using the continuation sheets and ongoing assessment tables.	As a result of this audit: DCH will restructure and condense the care plan according to new NICE Quality Standards for Care of the Dying patient; further education for staff will be provided on both the new care plan and difficult conversations e.g. regarding holistic patient needs and hydration. The care after death form and the bereavement checklist will be combined. These actions will be followed up through the End of Life Care Group.
4186 – Fast track continuing health care for patients who are dying	This audit found that: 60% of patients had the fast track process completed and were discharged to their preferred place of care, the remaining 40% died prior to the completion of the process; 29% of patients died within two weeks of the decision being made and 87% of patients died within three months of the decision being made; 38% of fast tracks forms took longer than 48 hours to complete; the average time to discharge home from agreement was 6 days to home, and 10 days to a nursing home.	These results have been fed back to the End of Life Care Group. The palliative care team will increase education around fast track; the recognition that somebody may be appropriate but also completion of the documentation. DCH will also liaise with CCG about results. A re-audit is planned later in 2018.
3794 – An audit of quality of end of life care	In the National End of Life Care audit – Dying in Hospital 2015 there were a number of areas where DCH performed below the national average. This re-audit reviews our	The actions around this audit are followed up through our End of Life Care Group. DCH will: review the end of life care plan; continue to

	performance against the national parameters. The audit shows an improvement in many areas of end of life care: recognising and documenting that a patient is dying and completing the relevant forms. Improvements in the prescription of anticipatory medications now exceeds the national average. Several areas still need improvement: documenting discussions with patients and families about wishes and preferences; assessing the patient holistic needs (spiritual and social); documenting assessment of the need for clinically assisted hydration: evidencing that symptoms have been controlled	strongly promote and encourage its use across the trust; introduce teaching specifically around holistic needs assessment and hydration assessment and discussions at the end of life; make use of DNACPR and DNE discussion to make earlier assessment of a patient's wishes and preferences.
Improving the safety and quality of medical handovers	This audit measured the quality of medical handovers before (Sept 2016) and after (Jan 2017) the introduction of Careflow. It provided assurance that Careflow has improved the recording of most parameters e.g. patient location, consultant caring for patient, diagnosis etc.	Careflow has been found to be affective and has been implemented throughout the Trust
4011 – A re-audit of acute management of neutropenic sepsis on presentation at DCH (audit carried out on an annual basis)	This is the 5th round of this audit which measures whether patients on chemotherapy attending ED with suspected neutropenic sepsis receive antibiotics within the target 1 hour of arrival. This audit found that there was only evidence of 47% patients meeting the target. This is significantly worse than previous cycles (at the last cycle there was 76% compliance). The discrepancy is thought to be due to a change to electronic prescribing, where the time of administration of the antibiotic is not always recorded.	As a result of this audit ED will: ensure better documentation of prescription and administration times of antibiotics; introduce handheld devices to allow timely prescription of antibiotics; continue to regularly audit ED notes and provide feedback to team; promote use of a proforma in ED and reiterate importance of prompt treatment of potential neutropenic sepsis.
4098- Quality of medical clerking following the introduction of single point clerking	Single point clerking was introduced at DCH for patients coming in under the medical take, allowing doctors and practitioners in the emergency department (ED) to complete the medical admissions proforma. The rationale for this was to optimise workflow by eliminating unnecessary, repeated work. This audit was carried out to provide reassurance that single point clerking is as safe as previous practice. Overall quality of clerking was poor, but no worse, following introduction of single point clerking.	This audit has shown that single point clerking has not reduced quality; however, it has identified the need for further work to improve the quality of clerking in general. A post take checklist is being considered. A re-audit is planned in 6 months.
4223 – An audit of compliance with the clinical pathway for admission to the ED	This audit found that the proforma was only being used for 69% of admissions to EDAU and only 70% met the inclusion/exclusion criteria. 94 % of patients leave the EDAU	As a result of this audit the ED team will ensure that the proforma is completed. Clinicians have also been reminded to complete all

Assessment Unit (EDAU)	within the target 12 hrs and of those 90% left within 8 hrs	documentation including medication prescription. A re-audit is planned in 2018
4326- Quarterly assessment of time from taking of samples for blood culture to loading on analyser in Microbiology against the PHE(Public Health England) standard of four hours	Previous audits showed an improvement in compliance from 41% to 96% following the installation of the new blood culture analyser. This audit showed that this improvement has been sustained (currently 95%)	DCH are Investigating whether extracting data from BacTec Epicentre is possible to give the exact time that the samples are loaded on the analyser, rather than using the receipt time in the laboratory. A re-audit is planned in February 2018
3885 – Surgical surveillance of infection(SSI) following orthopaedic hip replacement	For the audit period (April to June 2017) there were no postoperative infections. The SSI rate for hips over the last year is 1.3% compared to a national average of 1%.	A robust system is in place; cases are picked up through patient questionnaires and also positive wound swabs. The infection prevention and control team provide monthly updates to the Orthopaedic governance meeting. Infection prevention remains a priority for orthopaedics and surgical site infections will continue to be monitored
3915 – Surgical surveillance of infection (SSI) following breast surgery	For the audit period (January to March 2016) there were 4 postoperative infections (6.5% compared to a national average of 4.3%). Our SSI rate over the last year is 4.4%.	The infection prevention and control team will provide the breast surgeons with monthly reports. A clinical expert will attend the breast Morbidity and mortality meetings bi-annually to review cases
3708 – An audit of compliance with NPSA(National Patient Safety Alert) Naloxone guidance	This audit was carried out in response to a National Patient Safety Alert. Of the 21 patients prescribed Naloxone over a 2 month period, 9 cases of inappropriate administration were identified, 4 of which were judged to be avoidable because renal function had not been reviewed	These results have been reviewed by the medicine safety and clinical governance meeting. As a result of this audit a naloxone prescribing bundle is being created on EMPA and a safe medication staff bulletin has been produced to raise awareness. A re-audit is planned.
4172- Routine post-operative bloods in elective colorectal surgery patients	This audit was carried out to assess the appropriateness of post-operative bloods taken in patients who have undergone elective colorectal resections. It found that DCH are frequently ordering more blood tests than indicated by the most up to date research.	As a result of this audit F1's on general surgery rotation will be educated on the appropriate post-operative blood test regime. The colorectal team will liaise with IT to develop an ICE request panel for post-operative surgical patients.
3778 – Endoscopy patient satisfaction survey	As part of the programme to maintain Joint Advisory Group compliance the endoscopy team carry out an annual survey of patient satisfaction with the service. This survey of	As a result of this survey the endoscopy team will: contact the estates team to improve the temperature within the recovery

	100 patients found that overall we have maintained good standards of satisfaction. There is also clearer information in the waiting area. Areas identified for improvement are: ambience and confidentiality in the changing rooms; warmth within the recovery area ; communication between the nursing team and relatives in the waiting area	area; patients will be provided with dressing gowns if they don't have their own; use volunteer staff to bridge the waiting and clinical areas (improving communication with carers who are waiting)
3978 - A retrospective audit of the initial inpatient management of decompensated cirrhosis	This audit measured our performance for patients admitted with decompensated cirrhosis against the standards set in the BSG/BASL (British Society of Gastroenterology/ British Association for the Study of the Liver)care bundle. It identified lower performance in: The percentage of patients with ascites who had a tap performed; The percentage of patients with appropriate VTE prophylaxis; and the percentage of patients who had all electrolytes checked on admission. Areas of good performance included: checking of coagulation and correction of clotting abnormalities; management of variceal bleeding with tazocin and terlipressin; treating patients with alcohol excess with Pabrinex(Vitamins B&C injection).	The identified areas of poorer performance could likely be improved with widespread use of a liver bundle, adapted from the BSG/BASL bundle used for this audit. This links to the 2013 NCEPOD study into alcohol-related liver disease.
3950 – The management of abscesses using an ambulatory care pathway	This audit measured the impact of introduction of an ambulatory care abscess pathway. Prior to introduction of the pathway a significant proportion of cases were operated on out of hours. The audit found that introduction of the pathway reduced out of hours operating and reduced hospital admissions	The surgical team will consider the introduction of similar formalised pathways for other general surgical conditions e.g. right iliac fossa pain or biliary colic
4284 – Definitive management of Biliary Pancreatitis	The UK guidelines on management of pancreatitis issued by British Society of Gastroenterology(BSG) Guidelines state that all mild gall stones pancreatitis should have definitive management of lithiasis on the same admission or within 2 weeks. This audit found that at DCH all our suitable patients had timely laparoscopic cholecystectomy	We will continue to make junior doctors aware of the necessity for early cholecystectomy for simple gall stone pancreatitis
4310- Patient Flow in the Surgical Assessment Unit (SAU)	This audit of patients flow through our SAU against ambulatory emergency care network guidelines found: only 67% of initial nursing observations were carried out within the target 15 mins of arrival; only 59% of patients were reviewed by an FY1 within the target of 30 mins; 70% of patients were reviewed by a senior clinician within 2 hours; 80% had a	As a result of this audit nursing and medical staff will be made aware of the necessity of documenting the time the patient was seen. Junior doctors of the four surgical specialties who use the SAU (ENT, Urology, Gynaecology and general surgery) will be educated on the

	definitive decision within 4 hours. A concern of this audit was the poor documentation of timing of review by both nursing and medical staff	need for prompt review and SAU staff will bleep them when necessary
4285 – An audit of a ward round safety checklist	An initial audit carried out in autumn 2017 using the Royal College of Surgeons of Edinburgh's 'SHINE' ward round toolkit, found inadequacies in documentation on surgical ward rounds in several key areas. A ward round proforma was developed. This was introduced in Nov 2017 and a re-audit was carried out. At re-audit there was improved documentation of 16 out of the 18 domains.	The proforma will be transferred on to DPR, with electronic data such as bloods and observations pre-populated onto the proforma.
4163 - Weight Bearing in Ankle Fractures (WAX Audit)	This audit measured our performance in management of ankle fractures against the British Society of Orthopaedic Surgeon's guidelines. It found good compliance with these guidelines: 83.3% lateral mallelolar fractures were conservatively managed whilst 1 case an open fracture dislocation was operatively managed (which does not meet guidelines).	This audit was carried out over a short (2 week) time period and a re-audit over a longer time frame will better evidence our compliance with guidelines. The orthopaedic team will investigate whether there is a need for an increased use of weight bearing x-rays to assess fracture stability
4211 - Fracture Prevention Patient Survey	The aim of this audit was to establish a base line of patient's satisfaction with this new service. The Fracture Prevention Liaison Service has a unique opportunity to identify patients at risk of falling. Further promotion of the Fracture Liaison Service and the patient follow up process offer an excellent opportunity to tailor patient care.	The Fracture Prevention Service follow up calls are key to bringing the service together, from patient identification to treatment. The follow up calls for the service have been given priority providing more patient focused contact, with telephone clinics. The Clinical Review Team will now carry out a full falls assessment with the patient at home in a more timely manner. Re-audit in 12 months.
4273- ENT documentation & consent 2017	All standards were met with the exception of signing and printing name (50%). GP letter had printed name. No stamp was used after signing but GP letter was sufficient to confirm name.	All Doctors need to print their name after signing documents. Re-audit in 2018
4275 - Audit of patient assessment, diagnosis and management of non-acute hearing loss.	This audit found that patients with non-acute hearing loss referred to general ENT outpatient clinics have a significant wait for diagnosis and treatment and the majority breach hospital targets. It is not possible to distinguish acute from non-acute hearing loss all patients currently wait for consultant review. These patients could benefit from streamlined investigation leading to quicker	ENT will develop a 'virtual' clinic which screens patients referred with hearing loss. Patients will receive investigations quicker and resource can be focussed on patients who need consultant input. A re-audit will be carried out in January 2019.

	diagnosis and treatment	
3610 – Impacted maxillary canines; a local audit on the treatment outcomes of surgical exposure	Exposure of canine teeth success rate compares favourably with other published data. 97% of canines were successfully aligned (against a target of 92%). However 12% of canines required re-exposure (against the target of 6%). Average treatment time (22.7 months) compares favourably with published data (28 months).	The maxillofacial team will review their protocol for canine exposures including surgical technique, moisture control, the use of alternative bonding materials and a cover plate. The incidence of ankylosis (3%) will be discussed with patients during the consent process.
4057 – A re-audit of the surgical WHO checklist for intravitreal injections	An initial audit carried out in June 2016 found that Intravitreal Injection WHO Check-list used at that time was of poor quality and there was insufficient identification of ophthalmology staff involved in the process. As a result of this audit a new surgical checklist in line with the Royal College of Ophthalmologist and WHO Guidelines was prepared. Staff training also took place. This re-audit measured compliance with the checklist; compliance has improved greatly.	Non-compliant cases were reviewed at the departmental clinical governance meeting in June 2017. Some changes have been made to the form as a result of this. A re-audit is planned
4073 –REI casualty clinic service review	A previous service review carried out in 2016 led to appointment of a casualty eye clinic coordinator to improve management of casualty patients. This service review has found the changes made to be effective; there are reduced waiting times for casualty clinics and clinics are no longer overbooked. An ED fax referral form has been introduced which has eased the pressure for ED (since introduction there have been no eye casualty patient breaches).	Continued improvements are being made including: a Friday clinic all day prior to and a Tuesday clinic with protected slots following a Bank Holiday; a standardised fax referral form ; introduce emergency orthoptist appointments for triage of referrals
4213 – An annual re-audit of compliance with IRMER (Ionising Radiation Medical Exposure) regulations within the orthodontic department	This audit provides reassurance that DCH provide the required documentation of the review of dental radiographs taken for orthodontic purposes	DCH will continue to audit this annually
4181 – A survey of patient satisfaction at the end of treatment with orthodontic care (2017)	This survey measures patient satisfaction on completion from facilities in the department, to friendliness of staff to satisfaction with outcome. DCH continues to have high levels of satisfaction with 100% of patients 'very happy' or 'happy' with their results. The free text comments were analysed for common themes of less than optimal care and discussed within the department	No immediate actions are required. The survey will be repeated in 2018
4261 – An audit of the appropriateness and quality of new patient referrals to	This audit found that 81% of patients referred were appropriate in terms of severity of malocclusion. 18% did not have adequate oral hygiene to proceed with orthodontic	The results of this audit will be shared with referring dentists and guidance will be given on referring appropriately. The audit will be

the orthodontic department	treatment. The timing of the referral was appropriate in 74% of patients; none were too early and 26% were too late. 6.5% of patients referred did not want any treatment. The DNA rate was 6%.	shared with commissioners through the Orthodontic MCN(Managed Clinical Network)
3607 – Pregnancy screening in teenagers	This audit found that although 92% of 12-17 year old girls attending for surgery at DCH had a pregnancy check of some description, 62% of these were done through a parent questionnaire. There were differences in how pregnancy status was recorded between those assessed using the adult checklist and those using the paediatric checklist. In addition there was no formal explanation of the risk of not giving correct information about pregnancy status.	As a result of this audit the anaesthetic team are reviewing how to standardise pregnancy screening in this age group.
4329- A survey of confidence of use of prostaglandin by consultant anaesthetists in paediatric emergencies	This survey found that only 17% of Consultant Anaesthetists who attend paediatric crash calls were confident about drawing up prostaglandin in a paediatric emergency	A paediatric emergency prostaglandin box has been set up in SCBU, which contains all equipment and clear guidance on how to draw up and administer prostaglandin in an emergency. A re-audit is planned
3936 and 4282 – Intensive care infusion prescriptions – do they meet national standards?	An initial audit found that 40% of prescriptions did not meet all of the standards which are considered appropriate for drugs to be administered safely. A re-audit carried out in July/August 2017 found this to be improved (29%) and this is thought to be due to the diligence and experience of the nursing staff. However, this still falls short of the internal target (100%).	As a result of this audit pre-printed charts (which will have commonly prescribed medicines and dosages incorporated) will be introduced to ICU. The anaesthetists will also explore whether JAC EPMA can accommodate our infusion prescribing. A re-audit is planned in 6 months
4330 – An survey of training of anaesthetic trainees in tracheostomy emergencies	This survey of anaesthetic trainees who cover ITU found that although 60% of trainees were familiar with tracheostomy equipment only 40% felt competent in a tracheostomy emergency. Following a training course 100% of trainees now feel competent in management of tracheostomy emergencies.	Regular tracheostomy emergency training courses are planned every 6 months and will be made available to nursing staff and medical staff of all grades
3414 and 3775 – WHO Surgical checklist & theatre care pathway audit 2016/17	This audit monitors compliance and completion rate of the WHO Safer Surgery Checklist. DCH's overall compliance is comparable, Sign Out section where time pressure is greatest along with the Surgeon Signature remain lower than the Sign In and Time Out.	A task & finish group has been formed to look at the areas of lower performance: -Review which questions per section are not being completed and why -How Sign Out completion and Surgeons signatures can be improved - A more detailed audit of checklist required – all questions rather than just the overall sections
4082 - Ultrasound Guided Needle	This audit provides assurance that the diagnostic yield of ultrasound guided FNA	None required

Aspiration (FNA) Neck Lesions Diagnostic Yield	neck lesions is 76% at the Trust (against the Royal College of Radiology standard of at least 70%)	
3930 – An audit of appropriateness of outpatient CT(computerized tomography) requesting	This audit was carried out following increasing demand on the CT service. The aim of the audit was to ensure that all outpatients CT requesting was appropriate. The audit found that 91.8% of requests met the RCR iRefer Guidelines and were therefore indicated and appropriate. 7.23% did not meet RCR guidelines but were felt to be appropriate given local clinical practice.	The radiology department will maintain scrutiny of incoming CT requests. There are no plans for a re-audit but if inappropriate requests increase the formal audit will be undertaken
4101 – A re- audit of Breast Cancer surgery at Dorset County Hospital 2016: re-excision and completion mastectomy rates for screen detected and symptomatic breast cancers in comparison with NHS Breast Screening Programme Guidelines for Surgeons.	This re-audit demonstrates improved outcomes since the previous audit in July 2016. For Breast Screening Unit cases the re-excision rate is 6% (against a national target of 10-25%) and the symptomatic re-excision rate lies at 7% (against a national target of 10-25%.	No actions are necessary however a re-audit is planned for 2018.
4236 – An audit of completion of the Educational Healthcare (EHC) Plan medicals within 6 weeks from the request date	This audit showed that only 60% of EHC plan medicals were completed within 6 weeks of referral.	Each paediatrician has been made aware of their own results so that they can review clinic capacity to complete this statutory requirement.
4042 – A re-audit of the British Association for Sexual Health and HIV (BASHH) National Audit of the Management of Children under 16	This local re-audit of an initial national audit carried out in 2015 shows the GUM department to be fully compliant with the recommendations of the national group. Supplemental local action have also been fully implemented	None required
4079 – Quality of antibiotic documentation on maternity ward	This audit found that: 25% of patients did not have indications for antibiotics documented on their charts; 80% of patients did not have review/stop dates documented on their charts	As a result, this audit will be discussed with midwives to chase medical team to complete documentation. A notice will be put up notice in doctor's office to remind all members to complete their charts sufficiently

3886 – Patient satisfaction with the Forget me not Group (for bereaved parents who have lost a baby during pregnancy or after birth)	This satisfaction survey found that generally parents were happy with the 'forget me not' group and the bereavement services offered. There were suggestions that the Facebook group page could be used more to advertise events and organise meet ups. People welcomed the chance to talk to others who had gone through similar experiences	As a result of this survey: a reflection and sharing time will be set aside at each group for couples to tell their story, share memories/mementoes; we will explore arranging a counsellor/Sands worker to attend our group to see how this would benefit the group; the Facebook page will be more actively used to arrange other meetings outside the group.
3760 – Caesarean section (CS) re-audit	A previous audit our the CS rate was found to be above the national average; however, review of cases found no clear themes upon which actions could be targeted. This audit of births between Nov 2015 and March 2016 found an overall CS rate of 26% (11% emergency and 15% elective). The reasons for all CS's have been reviewed by the maternity team but no clear common theme has emerged against which actions can be targeted. However, the most common theme for elective CS was women who had had a previous CS and declined vaginal delivery for their next child.	As a result of this audit there will be: reorganisation of the Antenatal Day Assessment Unit to develop triage system; DCH will aim for more effective triage of primigravid women in early labour; a review of the service offered to women for elective CS
3968 - Gestational Diabetes Audit –are we managing patients promptly and effectively?	This audit was carried out to assess DCH compliance with NICE standards for gestational diabetes. It found that: 25% had their Hba1c measured at diagnosis; 47% of mothers with risk factors for gestational diabetes had a glucose tolerance test at the recommended 24-28 weeks; all patients were treated according to guidelines; 87% had follow up at their GP for postnatal glucose testing	As a result of this audit the maternity support worker has been tasked with undertaking an extra sample to measure the Hba1c at the time of the glucose tolerance test; Gestational diabetes leaflets are to be given to mothers at an antenatal visit; all patients with gestational diabetes will be entered on a spreadsheet (to facilitate future audit work); a re-audit is planned in 1 year
4137 and 4381 – WHO Checklist compliance in maternity theatres re-audits	In an initial audit carried out in 2016 DCH found that less than 50% of WHO Checklists carried out in maternity theatres were fully completed. A re-audit was carried out in 2017. It found that: in elective cases only 1 (6.6%) was not completed fully (compared to 50% previously); in emergency cases only 5 (18.5%) were not completed fully (compared to 79% in previous audit). In the latest re-audit compliance in completion of the WHO checklist remains below the expected standard. The WHO checklist alone was completed in 17 (47.2%) of notes. In terms of	The maternity team will continue to educate staff in a drive for 100% compliance A re-Audit is planned in September 2018

	the complete document, only 6 (16.6%) were fully completed.	
3990 - Prospective audit of aspirin compliance in pregnant women to reduce the risk of pre-eclampsia at Dorset County Hospital	This audit found that 53% of patients received appropriate risk assessment and counselling for receiving prophylactic treatment with aspirin.	The new National Maternity notes which have recently been introduced, prompt the clinician to risk assess women twice during pregnancy and refer as appropriate. Training on the use of the notes has been given to all staff.
3855 – Obstetric outcome of third degree tear audit	This audit was carried out to determine the incidence of adverse effects following obstetric anal sphincter injuries. In addition adherence to the Royal College of Gynaecologists and NICE guidelines was measured. 205 women were audited over a 5 year period: 95% of women had a systematic examination of the perineum, vagina and rectum; 6% suffered from faecal incontinence; 8% dyspareunia; 2% had other complications such as urinary incontinence and painful stitches.	As a result of this audit DCH will review at around 12 weeks postpartum (to pick up complications such as dyspareunia). The gynae team will, decide whether to carry out routine endoanal ultrasonography and/or manometry at follow up. The routine prescription of laxatives and/or bulking agents will be reviewed.
3960 – An audit into the accessibility of water and call bells for adult inpatients	This snapshot audit across medical and surgical wards audit measures DCH compliance with our Food and nutrition policy that all patients should have access to fresh water. In addition our Prevention and Management of Slips, Trips and Falls Policy states that all patients should have a falls assessment within 4 hours of admission, should have a call bell within reach and should be instructed on the use of their call bell. The audit found that: adult inpatients often cannot reach their call bell; the majority of inpatients have access to fresh water; surgical wards generally have a higher rate of compliance with water and call bell availability; a very low percentage of elderly care patients know how to use the call bell.	As a result of this audit there will be a one month one ward trial with laminated outline mats on bedside tables to see if this increases compliance. Awareness poster will be displayed on wards. The team are exploring the feasibility of water and call bell stewards for each ward and also an awareness week across the Trust. A Re-audit is planned
3912 – An audit of adequacy of post-operative analgesia upon discharge from hospital	This audit of patients from DCH in a 6 month period to one GP surgery (Bere Regis) found that: 96% of patents were provided with adequate analgesia; 2/3 patients requiring laxatives/anti-emetics in the post-operative period were provided with them, and this results in extra visits to the GP; the most common reason for GP review was constipation or nausea	As a result of this audit a meeting has been arranged with pharmacy to ensure that appropriate counselling occurs prior to discharge including advice about over the counter medication for pain/nausea/constipation. A leaflet is being developed about the over these over the counter medications.
Clinical Coding audits: 4063 – Obstetrics	These audits are carried out in each speciality to improve the accuracy of coding data. 50 episodes of care are randomly re-coded.	The results of these audits are used by the coding team for training of coders. Clinicians

3830 – Diabetic medicine 4235 – General Surgery 4251 – Gynaecology	Coding errors are identified and the financial impact or these errors (and of non-coding errors) is assessed.	are also educated on the importance of accurate Electronic Discharge Summaries which include a record of co-morbidities
4331 – DNAR Spot Audit	This audit follows on from the DNAR Compliance audit carried out in June 2017, looking specifically at whether the time and date of the DNACPR is clearly documented in the patient's medical notes or the new yellow sticker completed and placed in the notes. The results show an improvement on this standard from 58% in June to 85% in January 2018.	DNAR training will continue as part of the BLS/Mandatory updates, and a repeat audit carried out in March 2018 to ensure compliance continues to improve.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2017 -2018 that were recruited during that period to participate in research approved by a research ethics committee was 1307*.

This is the highest involvement achieved to date, and represents 168% of our forecasted recruitment for this period.

**The cut-off date for submitting recruitment information for 2017-18 is 20th April 2018, and whilst the majority of recruitment is already captured there may be a small increase in the final figure.*

A proportion of the Trust's income in 2017- 2018 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation Payment framework.

In 2017 – 2018 2.41% of our clinical income depended on achieving these goals. This equated to £3,262,580, of which we secured £3,241,785 (99.3%). **The Trust did achieve 100% of all the payment available, the lower payment reflects changes in activity levels affecting the level required.*

The Trust is required to register with the Care Quality Commission (CQC) and its current status is registered in full without conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2017- 2018.

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

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

	2014/15	2015/16	2016/17	2017/18	National Average
Admitted Patient Care	99.9%	99.9%	99.9%	99.9%	99.4%
Outpatient Care	99.9%	100%	100%	100%	99.6%
Accident and Emergency Care	99.3%	99.2%	99.2%	99.1%	97.4%

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

	2014/15	2015/16	2016/17	2017/18	National Average
Admitted Patient Care	100%	99.9%	99.9%	100%	99.9%
Outpatient Care	100%	99.9%	100%	100%	99.8%
Accident and Emergency Care	100%	99.5%	99.7%	100%	99.3%

The Trust's Information Governance Toolkit Annual Assessment for 2017-18 was 82% and graded Unsatisfactory (red) due to a failure to meet Requirement 14.1-112 at a Level 2 "*At least 95% of all staff have completed their annual IG training in the period 1st April to 31st March*". There is an improvement plan in place, approved by the Health Informatics Programme Board to reassess training needs and bring the training compliance level up to the required standard by the end of May 2018.

The Trust was not subject to the Payment by Results clinical coding audit during 2017 – 2018.

Learning from Deaths

The Trust reviews all patients that have died and identifies from those patients that require further in depth reviews, using the Learning from Deaths national guidance. ('*National Guidance on Learning from Deaths*', National Quality Board, March 2017).

During 2017-2018 at total of 759 DCH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

199 in the first quarter;
159 in the second quarter;
199 in the third quarter;
202 in the fourth quarter.

By 31st March 2018, 410 case record reviews and 4 investigations have been identified in relation to 410 of the deaths included in the above.

In 4 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

146 in the first quarter;
109 in the second quarter;
107 in the third quarter;
48 in the fourth quarter;

As confirmed by NHS Improvement, Acute providers were not required to judge whether the death was avoidable, but are required to identify key learning from deaths and whether there were care issues that may have contributed to the death. Mortality reviews include all 'phases' of care experienced by the patient while under the care of the hospital. The reviews follow the Royal College of Physicians training guidance and reporting. ('*National Mortality Case Records Review Programme'*, Royal College of Physicians, January 2017).

There is further work being undertaken with our community and primary care partners to review patients that die out of hospital.

The Trust publish the outcomes of these reviews through the Public Board papers and have a Hospital Mortality Group to review findings from the reviews to ensure good practice and learning is shared. This feeds into the quality improvement plans in the Trust, as part of the overall Trust objective to deliver outstanding services every day.

Overall positive good practice themes are noted to be in a high proportion of the record reviews, which are summarised below:

- Rapid escalation to appropriate specialities
- Excellent initial assessments and clerking by Nurse Practitioners
- Good support from Critical Care Outreach team
- Good evidence of decision making processes and appropriate treatment plans
- Good quality care

Themes noted for improvement have been identified in a few case reviews, these include:

- Failure to escalate a deteriorated patient in a timely manner
- Delay in 'Sepsis six' screening and management
- DNAR (Do not attempt resuscitation) and incomplete use End of Life Care planning
- Substandard documentation and legibility of some written records

As a consequence of what the Trust has learnt during the reporting period, a brief summary of the actions taken

- Sepsis bundle usage – Further work with the Wessex Patient Safety Collaborative in re-design of the Sepsis Six screening tool. Implementation of a prompt in the electronic vital signs tools used by clinical teams. Audits of sepsis screening, which have demonstrated improvement, as per the Trust performance dashboard. The learning has been shared via Divisional Newsletters, Departmental Care Group Clinical Governance meetings and the Sepsis/ Deterioration Group to highlight the importance and raise awareness amongst staff.

- End of life recognition and care – This has been shared at the Hospital Mortality Group meeting and End of Life Care Group. The End of Life Care group have audited the use of the care planning document and feedback received from clinicians has been that the document is too complicated; this is now being reviewed and modified. In addition, there is improvement work across Dorset with all partners to improve cross organisational planning of end of life care and communication.

- Poor documentation and legibility – This has been highlighted in junior doctor training and cascaded through Divisional newsletters and Divisional Governance meetings, with examples identified. The Trust has invested in and is implementing a Digital Patient Record which will eliminate this in the future.

- DNAR decision and documentation – This has been highlighted in the Divisional newsletter and discussed at education forums. There is ongoing auditing to identify areas of poor compliance so that more focused work can take place.

The Trust takes pride in the vast majority of the mortality reviews which show good quality care. However as the Trust strives for continuous improvement any areas that are identified as concerns report into the overall appropriate forum to make those improvements. As such, while actions are ongoing, there have been real improvement areas such as the Sepsis screening (referred to in the quality account priorities). DNAR audits have demonstrated improvements in such areas as the location of the DNAR form (81% to 94%) and valid completion date/time from 85% to 88% between September 2017 and April 2018.

There have been no case record reviews or investigations completed after 31 March 2018 which related to deaths which took place before the start of the reporting period.

Reporting Against Core Indicators

Mandatory Statement 12: Mortality

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

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

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

Summary Hospital-level Mortality Indicator	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18*	Trend
Banding	**2**	**2**	**2**	**1**	**2**	**N/A**	
Value	**1.07**	**1.11**	**1.10**	**1.16**	**1.12**	**N/A**	
% of patient deaths with palliative care coded at either diagnosis or speciality level	**12.0%**	**13.5%**	**15.7%**	**24.9%**	**35.6%**	**N/A**	
National Average	*19.9%*	*23.6%*	*25.7%*	*28.5%*	*30.7%*	*N/A*	
Lowest	*0.1%*	*0.0%*	*0.0%*	*0.6%*	*11.1%*	*N/A*	
Highest	*44.0%*	*48.5%*	*50.9%*	*54.6%*	*56.9%*	*N/A*	

Data published 6 months in arrears, 2017/18 to be published September 2018

The England average SHMI is 1.0 by definition, and this corresponds to a SHMI banding of 'as expected'. For the SHMI, a comparison should not be made with the highest and lowest trust level SHMIs because the SHMI cannot be used to directly compare mortality outcomes between trusts and, in particular, **it is inappropriate to rank trusts according to their SHMI**.

Source

https://beta.digital.nhs.uk/search/category/summary-hospital-level-mortality-indicator--shmi-

The Trust has seen an increase in SHMI and a decrease in banding. This is being reviewed through the Hospital Mortality Group.

Mandatory Statement 18: PROMs

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

Patient Reported Outcome Measures (PROMs)	2012/13	2013/14	2014/15	2015/16	2016/17*	2017/18	Trend
Groin Hernia							
Dorset County Hospital	**0.076**	**0.076**	**0.066**	**N/A**	**0.068**	**N/A**	
National Average	*0.085*	*0.085*	*0.084*	*0.088*	*0.086*	*N/A*	
Lowest							
Highest							
Hip replacement							
Dorset County Hospital	**0.461**	**0.445**	**0.466**	**0.471**	**0.462**	**N/A**	
National average	*0.438*	*0.436*	*0.437*	*0.438*	*0.445*	*N/A*	
Lowest							
Highest							
Knee replacement							
Dorset County Hospital	**0.304**	**0.297**	**0.305**	**0.341**	**0.299**	**N/A**	
National average	*0.318*	*0.323*	*0.315*	*0.320*	*0.324*	*N/A*	
Lowest							
Highest							
Varicose Vein							
Dorset County Hospital	**N/A**	**N/A**	**0.099**	**0.127**	**0.043**	**N/A**	
National average	*N/A*	*0.093*	*0.095*	*0.096*	*0.092*	*N/A*	
Lowest							
Highest							

Provisional data for 2016/17. Finalised due to be published in August 2018

NHS England discontinued the mandatory varicose vein surgery and groin-hernia surgery national PROM collections from October 2017

Source

https://digital.nhs.uk/patient-reported-outcome-measures

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

Mandatory Statement 19: Readmissions

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

Readmissions within 28 days	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Trend
Aged 0 to 15 years							
Total Spells	5,147	4,749	4,676	4,948	4,975	4,778	
Of which, readmitted as an emergency within 28 days	456	393	442	471	488	478	
Dorset County Hospital	**8.9%**	**8.3%**	**9.5%**	**9.5%**	**9.8%**	**10.0%**	
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Aged 16 years and over							
Total Spells	16,832	16,103	17,567	18,263	18,837	17,957	
Of which, readmitted as an emergency within 28 days	1,741	1,695	1,994	2,222	2,295	2,142	
Dorset County Hospital	**10.3%**	**10.5%**	**11.4%**	**12.2%**	**12.2%**	**11.9%**	
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Highest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	

Source Internal DCH report which follows the guidance as stated on p22 of:
https://improvement.nhs.uk/uploads/documents/Detailed_req_for_assurancefor__qual_repts_16-17_.pdf
NHS Digital has not published the recommended source reports since December 2013

Mandatory Statement 20: Responsive

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

Responsiveness to the personal needs of patients	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18*	Trend
Dorset County Hospital	**66.9**	**69.9**	**71.1**	**69.6**	**70.2**	**N/A**	
National average	*68.1*	*68.7*	*68.9*	*69.6*	*68.1*	*N/A*	
Lowest	*57.4*	*54.4*	*59.1*	*58.9*	*60.0*	*N/A*	
Highest	*84.4*	*84.2*	*86.1*	*86.2*	*85.2*	*N/A*	

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

Mandatory Statement 21: Staff Friends and Family Test

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

Staff survey feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	2015	2016	2017
Dorset County Hospital	74%	76%	**76%**
National Average (median)	69%	70%	**71%**

Staff FFT feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	Quarter 1	Quarter 2	Quarter 4
Dorset County Hospital	75%	69%	81%
National Average (mean)	83%	81%	
Highest	97%	100%	
Lowest	29%	43%	

The Trust has taken a number of actions to improve staff satisfaction and in turn the quality of its services. Actions taken in 2017 in response to staff feedback include the roll out of phase 2 of the Trust-wide leadership development programme; which delivers training to staff within bands 4-6 alongside investment in coaching, training and development for staff. Further work continues this year to continue to improve based on staff feedback, in line with the Trust's Staff Engagement Action Plan and to refresh our people strategy.

Mandatory Statement 23: VTE

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

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

Rate of admitted patients assessed for VTE	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Trend
Admissions	24,026	87,426	91,462	96,063	96,797	98,692	
Of which, VTE risk assessed	22,077	85,211	87,371	92,847	92,813	94,793	
% VTE risk assessed	**91.9%**	**97.5%**	**95.5%**	**96.7%**	**95.9%**	**96.0%**	
NHS Standard	*92.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	
National Average	*94.0%*	*95.8%*	*96.1%*	*95.8%*	*95.6%*	*95.3%*	
Lowest	***80.2%***	***66.7%***	***88.6%***	***76.9%***	***0.0%***	***77.4%***	
Highest	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	

2017/18 national data upto December 2016. Q4 data to be published June 2018

Source

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

https://improvement.nhs.uk/resources/vte/

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

Mandatory Statement 24: C-Difficile

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

C-difficile rates per 100,000 bed-days	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18*	Trend
Bed-days	101,156	102,674	98,654	105,719	103,238	N/A	
C-difficile cases	22	27	15	24	13	N/A	
C-difficile rate	**21.7**	**26.3**	**15.2**	**22.7**	**12.6**	N/A	
National Average	*17.4*	*14.7*	*15.0*	*14.9*	*13.2*	*N/A*	
Lowest	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*N/A*	
Highest	*31.2*	*37.1*	*62.6*	*67.2*	*82.7*	*N/A*	

2017/18 data published July 2018
Source
https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

Although the Trust did experience an increase in C-difficile rates (as consistent with the national picture), significant reductions were made in 2016/17. Data is yet to be nationally published, but internal data identifies that this improvement has continued into 2017/2018.

Mandatory Statement 25: Incidents

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

Patient safety incidents reported	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18*	Trend
Number of patient safety incidents reported to NRLS	2,945	1,736	2,116	4,609	4,493	N/A	
Admissions	51,184	50,530	98,666	105,413	99,883	N/A	
Incident rate per 100 admissions	**5.8**	**3.4**	**2.1**	**4.4**	**4.5**	**N/A**	
National Average	*7.1*	*7.7*	*3.6*	*3.9*	*4.1*	*N/A*	
Lowest	*2.5*	*3.0*	*1.7*	*1.6*	*1.9*	*N/A*	
Highest	*27.8*	*30.4*	*10.2*	*13.0*	*14.8*	*N/A*	
Incidents resulting in severe harm or death	25	3	19	25	24	N/A	
Percentage of incidents resulting in severe harm or death	**0.85%**	**0.17%**	**0.90%**	**0.54%**	**0.53%**	**N/A**	
National Average	*0.65%*	*0.55%*	*0.49%*	*0.41%*	*0.37%*	*N/A*	
Lowest	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*N/A*	
Highest	*3.34%*	*3.90%*	*4.18%*	*1.74%*	*1.58%*	*N/A*	

Data published 5 months in arrears, 2017/18 data published August 2018
Source
https://digital.nhs.uk/data-and-information/indicators/indicator-portal-collection/quality-accounts/domain-5

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

Part 3 – Other Information

Care Quality Commission (CQC) Rating

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

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

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

Patient Safety – Reducing avoidable harms from Hospital Falls

Goal for 2017-2018:

We will reduce the number of hospital falls resulting in severe harm by 10% compared to 2016-2017.

What is a hospital fall?

Hospital Falls have a major impact on patients experience of care, cause unnecessary pain, cost significant resources to treat and increase the lengthy of hospital stay. The human cost of falling includes distress, loss of confidence, loss of independence and increased morbidity and mortality.

In 2015/16, as in previous years, falls were the most commonly reported type of incident in acute and community hospitals.

The National Reporting and Learning System (NRLS) requires reported to assign one of five degrees of severity of harm:

- No Harm – no harm came to patient, no visible bruising
- Low Harm – required first aid, minor treatment e.g. Graze on hand
- Moderate Harm – likely to require outpatient treatment, surgery or longer hospital stay e.g. Fractured Pubic Rami
- Severe Harm – where permanent damage, such as brain damage or disability was likely to result from the fall e.g. Fractured Neck of Femur
- Death – where the death was a direct result of the fall

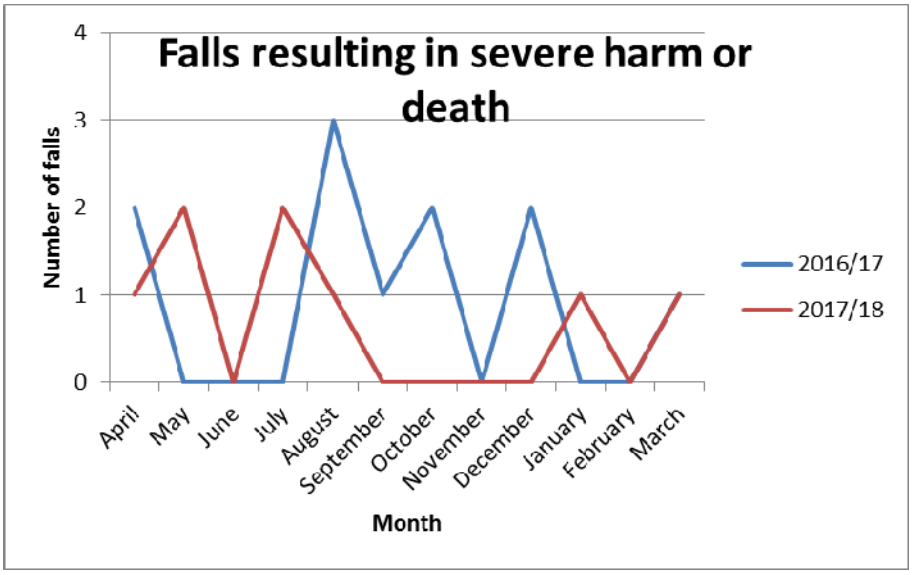
Although the reasons why patients fall is often multifactorial, some measures can be put in place to reduce the risk of falls, or likelihood of injury during a fall. Guidance from NHSI '*The Incidence and costs of inpatient falls in hospitals*' (July 2017) recommended that trusts should be ambitious in setting targets to reducing avoidable falls, but reducing falls to zero will not be a realistic target for any hospital due to:

- Trusts will always have to make a challenging trade-off between encouraging patient mobility and independence and minimising the risk of falls
- In some cases, falls will be a necessary part of a patients rehabilitation process
- The cost of trying to eliminate all risk is likely to be prohibitively high

How did we perform?

Total numbers:

	2016-2017	2017-2018	Percentage Reduction
Falls resulting in severe harm or death	11	8	**27%**



In summary, the Trust has seen a consistent decrease in the number of falls. The graph above demonstrates an increased occurrence of falls observed annually in the July to August period. The Trust will be working on the themes associated with this for 2018/19 to identify any factors that may be contributing towards this and will continue to monitor this priority through the internal Quality Committee.

Patient Safety – Improved Mortality Surveillance and Reducing Variation

Goal for 2017-2018:

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

What is mortality surveillance?

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

What is the Summary Hospital-level Mortality Indicator?

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as a National Statistic by NHS Digital.

The SHMI is the ratio between the actual number of patients who die at the trust or 30 days post discharge and the number that would be expected to die given the total risk of the patients treated there using a nationally approved methodology.

How did we perform?

We constantly monitor our performance against the National Standards and our peers and we have noticed that over the last two years (July 2014 – Dec 2016), our performance on this particular indicator (SHMI) has been consistently higher than the national average. A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance. Instead, it should be viewed as a 'smoke alarm' which requires further investigation by the trust. Similarly, a 'lower than expected' SHMI should not immediately be interpreted as indicating good performance. In that respect, a significant amount of work has been happening since January 2017 to improve to data quality issues related to clinical coding. As a result, we have seen a decrease on the Trust's SHMI in the period from April 16 – March 17. However, a national change in the guidelines for Sepsis coding had a negative impact on our SHMI score in the next two periods (July 16- Jun 17, October 16 – September 17) as it can be seen on Figure 1. The latest SHMI figure (shaded differently) is marginally over the upper threshold by 0.001, hence our Trust remains on the "higher than expected" band.

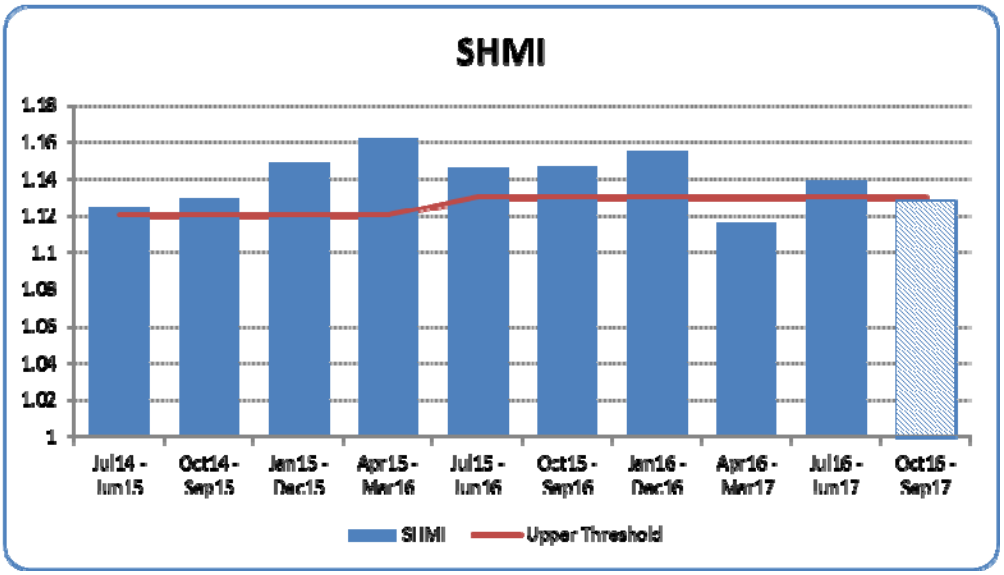


Figure 1 SHMI OVERVIEW

The crude mortality rate for DCH remains stable which is an indicator that the quality of care has not changed significantly over this period.

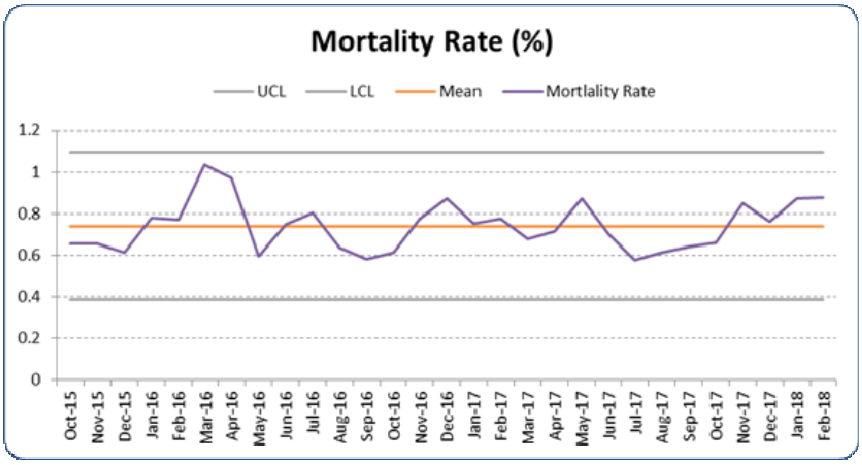


Figure 2 is an SPC chart that shows that the Trust crude mortality has normal variation over the last 29 months

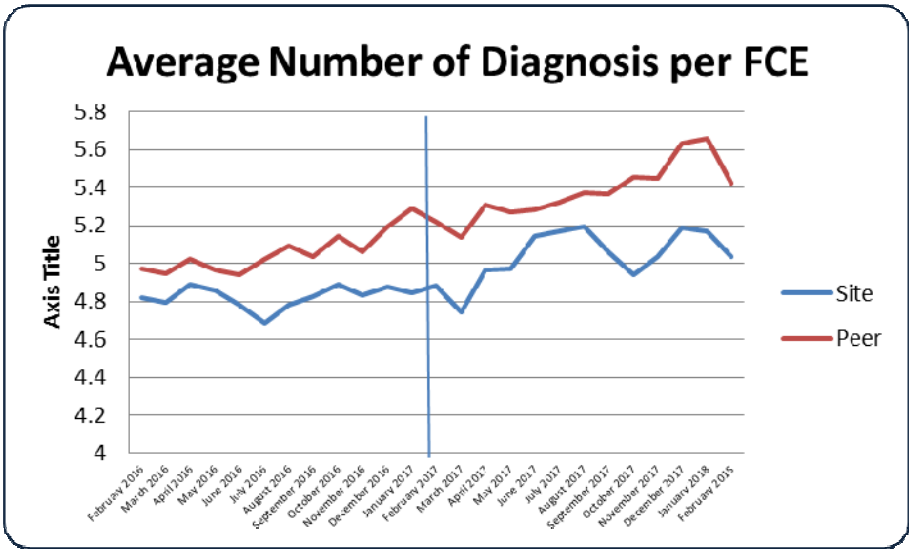
Further analysis of the data quality indicators showed there were some reporting issues that contributed to the increased SHMI before January 2017. An improvement action plan to reduce SHMI has been agreed and approved by the Quality Committee and its implantation began in January 2017. A dashboard with all the contextual indicators that can impact SHMI was produced and monitored on a monthly basis.

The Summary Hospital-level Mortality Indicator (SHMI) score depends on the accurate and timely recording of patient data including a definitive diagnosis and an accurate list of their comorbidities. The information captured by the clinicians should be translated by the Clinical Coding team to diagnostic codes which allows a relevant risk to be associated with the diagnosis. The analysis of our data has shown that a rather high number of non-elective patients (17.18%) did not have a definitive diagnosis during the first two episodes of their treatment.

Description	Mar 17 - Feb 18	Mar 16 - Feb 17	Change	Site Numerator	Site Denominator	Peer Value	Performance
Sign or symptom as a primary diagnosis	6.325%	7.692%	-17.778%	7389	116828	10.493%	
1 - Elective	2.7597%	2.9779%	-7.325%	2234	80950	5.131%	
2 - Non-elective	14.368%	17.182%	-16.375%	5155	35878	14.653%	

These patients were assigned a “Sign or Symptom Code” rather than a definitive diagnosis code. . The risk score associated with a “Sign or Symptom Code” tends to be lower than a definitive code which causes the mortality indicator (SHMI) to rise. Over the last year, as a result of the improvements made by the clinical coding team, we have noticed a significant improvement to the coding of both elective patients (-7,32%) and non-elective patients (-16,37%).

Similarly, we have noticed a rather low number of comorbidities recorded for DCH patients compared to the national average and that of our peers. Given the case mix of our patients, we would expect that the average number of comorbidities per spell to be closer or even higher than our peers (which have a similar case mix of patients). As part of the improvement action plan, we have managed to increase the average number of diagnosis by 4.3% but further work will be required in order to achieve our target which is to be better than our peers.



Patient Safety – Improving early identification and treatment of Sepsis

Goal for 2017-2018:

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

What is Sepsis?

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

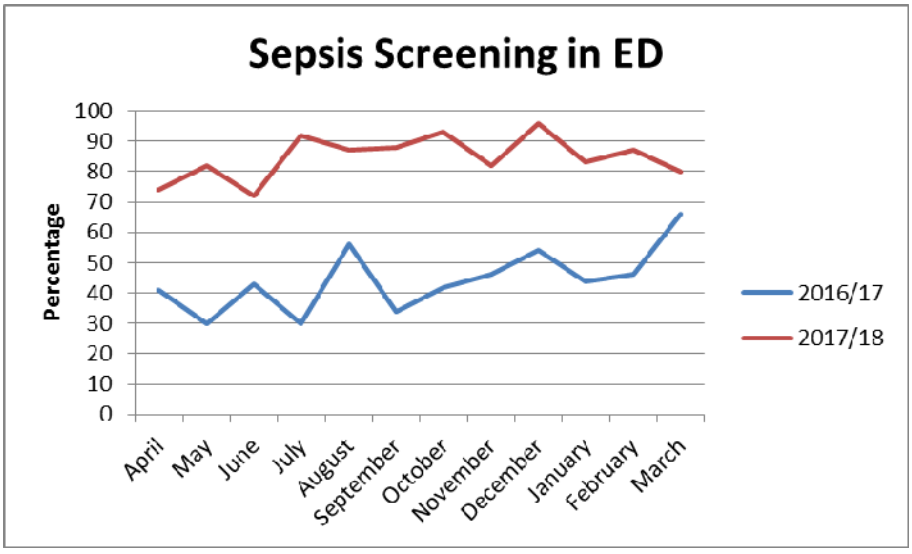
Sepsis kills 44,000 people annually in the United Kingdom. International estimates of incidence vary, but consensus points to approximately 300 cases per 100,000 population per annum.

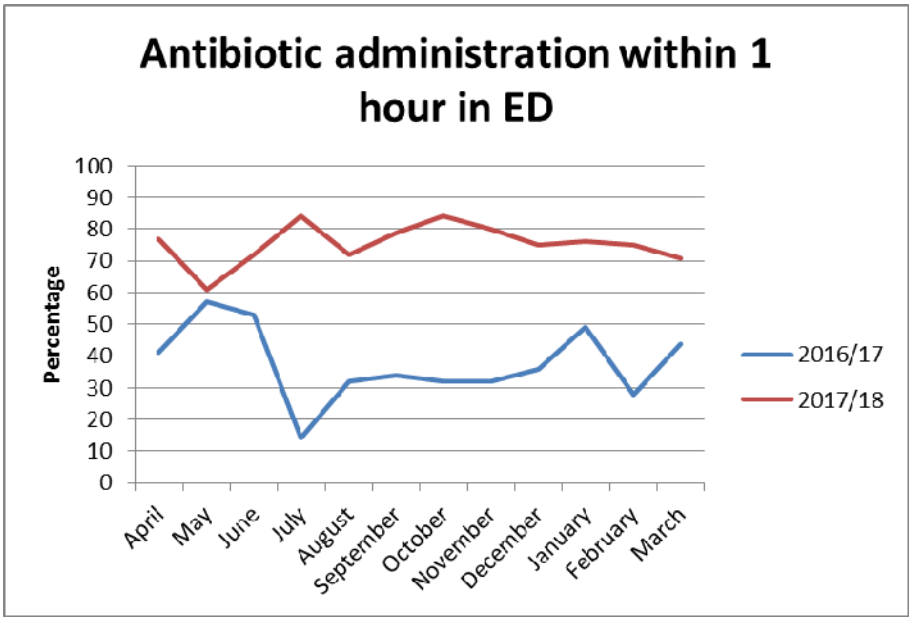
The early identification and treatment of sepsis has been demonstrated to reduce mortality from sepsis by 50%.

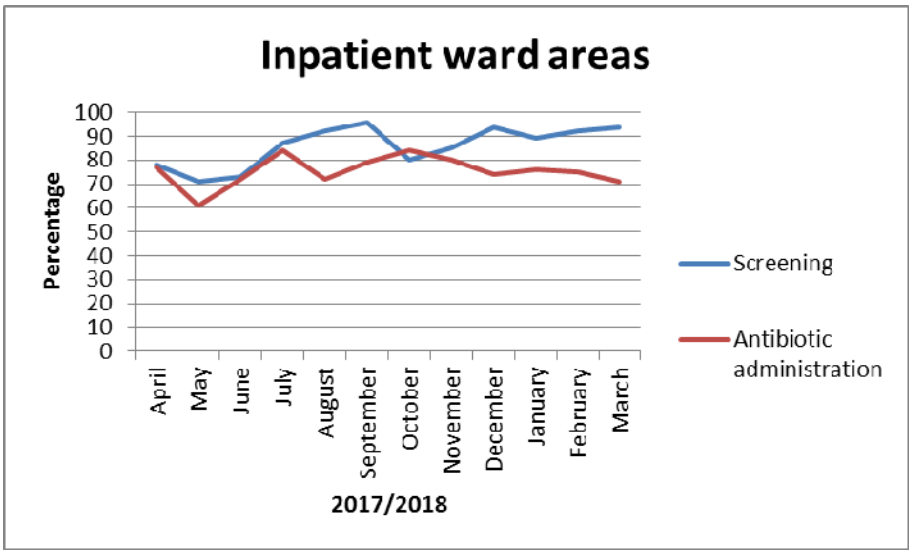
How did we perform?

The Trust has been committed to awareness raising events to support staff in the identification and screening of Sepsis and has continued with its theme of having a 'Sepsis Week' in September 2017.

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







Although the Trust recognises that there have been significant improvements made, there is further progress required in this area as it did not achieve its target improvement. The work plan of the Quality Committee has been refreshed to maintain the monitoring of this indicator. The Trust did not collect the screening or antibiotic administration statistics for Inpatient ward areas in 2016/2017 so it is not possible to show a comparison, but it will be for the forthcoming quality account.

Clinical Effectiveness – Improving the support from Hospital Volunteers to have positive effects on clinical outcomes (Loneliness Agenda)

Goal for 2017-2018:

We will seek to identify areas in which hospital volunteers can be used to enhance the experiences of our patients, and support our staff

What are Hospital Volunteers?

Hospital volunteers provide practical help to patients and visitors, complementing the work of paid staff across the Trust. They do not carry out clinical work or do work experience.

Volunteers are not directly involved in patient care but help provide extra support. They come from all walks of life and represent the diversity of the communities that we serve.

How did we perform?

In January 2018 the Trust submitted a funding bid to the Government's #iWill fund, aimed at attracting young volunteers to the hospital. Funding was approved in March 2018, giving the Trust financial assistance for two years to aid us in revitalising the current volunteer service, and to work towards attracting young people to come and volunteer with us.

We are currently in the process of advertising for a Volunteer Co-ordinator to implement the plan to develop and re-invigorate the volunteer service.

Our aim is to completely redesign the existing volunteer service and work exclusively towards attracting young people to volunteer with us in high impact volunteering roles such as befrienders and mealtime assistants that will make a measurable and valuable difference to our patients and their carers/relatives.

The Trust is committed to engaging volunteers in meaningful roles that enhance our services and add value to the patient and family experience. As such, the Trust will look to ensure that our young volunteers are well placed, inducted, trained, supported and celebrated throughout their time of volunteering to guarantee the best possible practice and service.

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

Goal for 2017-2018:

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

What is an Electronic Discharge Summary (EDS)?

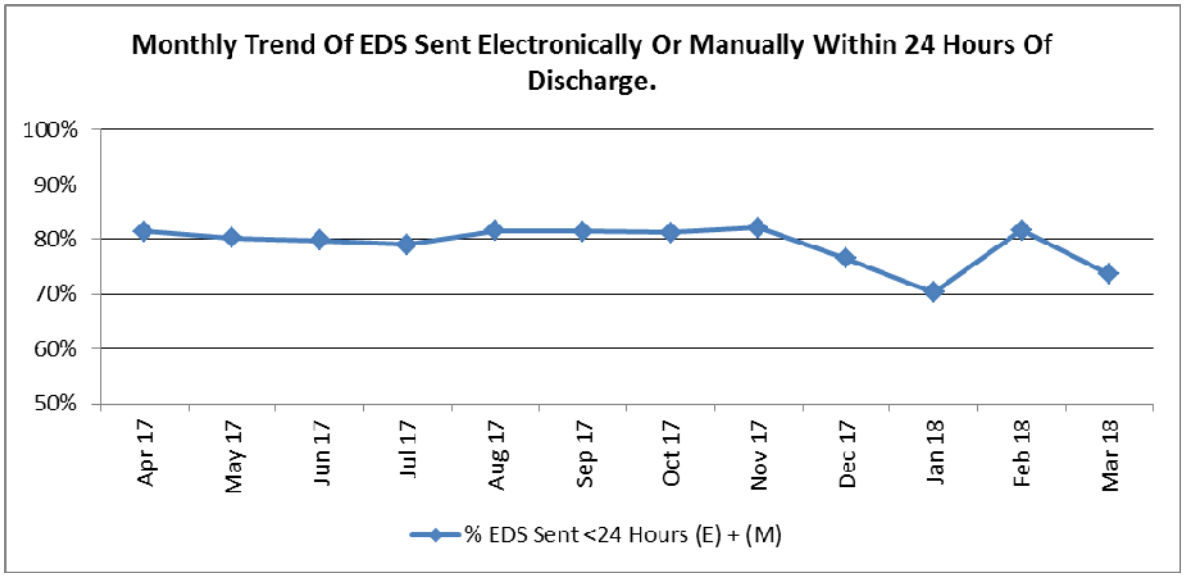
A discharge summary is an electronic letter written by the doctor (or nurse) caring for the patient in hospital. It contains important information about the hospital visit, including:

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

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

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

How did we perform?



Outstanding EDSs for the second quarter of 2017/18 are now 4 and are known to the Urgent & Integrated Care Division. The Q3 2017/18 backlog is currently 21 incomplete EDSs, with Q4 currently 121 incomplete EDSs.

The challenges to clear the backlog remain the same. Capacity across all areas, including administration resource to go through the backlog and order notes, super-user/ICE system manager capacity to cleanse the data of user errors, medical records capacity to provide the notes and Junior Doctor capacity to complete have contributed to this challenge.

The software provider has updated the system with the required changes to ensure EDSs are no longer uncompleted due to the interface with JAC and ICE. This means the reports that are sent to the divisions on a weekly basis are accurate. This came into effect on 24 July 2017.

The admin process for patients has been reviewed and amended to ensure the patient remains under the correct Consultant; therefore the EDS will be completed by the correct team.

Whilst there are still some process issues being worked through, the quality and risk impact continues to be reduced as a result of the work to date. An in house minor ICE system change was implemented in January 18 to support the reduction of user errors. From a breakdown of findings from January's perfect week and the 1st week of March 18, the number of data quality issues in a sample of 50 patients has reduced from 23% to 8%.

There are 105 GP surgeries able to receive EDSs electronically. Of the Dorset GP Practices 93% are receiving Electronic Discharge Summaries. Since April 17 the % of EDSs sent manually has dropped from 6.32% in April 2017 to 3.30% in February 2018, this figure appears stable over the last 4months.

In addition to the above actions, the internal auditors (KPMG) were requested to carry out an assurance audit focusing on EDSs and a draft report was completed on 3 April 2018. This report is due to be presented to the audit committee on 22 May. Initial findings show that KPMG have provided an assurance rating of 'Significant assurance with minor improvement opportunities'. The divisions will be asked to consider the final report and take any necessary action.

Clinical Effectiveness – Promoting the Health and Well-being of staff

Goal 2017-2018:

To identify and promote schemes available for staff at the Trust to improve or enhance their health and wellbeing.

What is the promotion of health and well-being?

The Trust recognises that its employees play a vital role in its aim to provide 'outstanding care for people in ways which matter to them'. The staff have a direct impact on the clinical outcomes and the experience of our patients. We are clear that when our staff are feeling well and satisfied with their work, the experiences of our patients improves. It is for these reasons that the trust has worked with local businesses and initiatives to offer staff the ability to improve their health and wellbeing.

How did we perform?

Some of the schemes implemented by the trust include:

Occupational Health & Wellbeing

The role of the Occupational Health (OH) and Wellbeing Department is to act in an advisory capacity to both staff and managers to promote and maintain the highest possible levels of health and wellbeing in the workplace. The OH and Wellbeing service is both confidential and impartial.

Care First

Care first are a leading provider of professional counselling, information and advice offering support for issues arising from home or work. They employ professionally qualified Counsellors and Information Specialists, who are experienced in helping people to deal with all kinds of practical and emotional issues.

All Staff can access Care First, who will provide additional support in both work and non-work related matters. From work-life balance to childcare information, relationships to workplace issues, health & wellbeing. Topics include (but are not limited to) Debt, disability & illness, bereavement & loss, stress, elder care information, life events, anxiety & depression, family issues, education, consumer rights.

Physiotherapy

All staff can access physiotherapy services via self-referral or through their line manager.

Stress Management

The Trust recognises that work-related stress is a health and safety issue and acknowledges that there are potential risks to the mental and physical health of employees from prolonged exposure to stress.

The Management of Stress at Work Policy and procedural guidance applies to all Trust employees and, in common with all Workforce and Human Resources policies and procedures, forms an integral part of contracts of employment. In line with this the Trust will identify causes of workplace stressors and conduct risk assessments to eliminate stress where reasonably practical or control the risks associated with stress.

Counselling Support

The Trust provides a face-to-face counselling service, which is available to all staff.

Chaplaincy Service

Chaplains are employed by the Trust to provide confidential support and pastoral care to patients, carers and staff. This support is completely confidential and available to people of all faiths and none.

The Chapel is also available at all times of the night and day as a place of quiet reflection and prayer.

Patient Experience – Improving the identification, assessment and referral for patients with Dementia

Goal 2016-2017:

We will improve our screening for dementia, appropriate assessment of those patients identified as having possible dementia and our onward referral to specialist services to greater than 90%

What is Dementia?

The word 'dementia' describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. These changes are often small to start with, but for someone with dementia they have become severe enough to affect daily life. A person with dementia may also experience changes in their mood or behaviour.

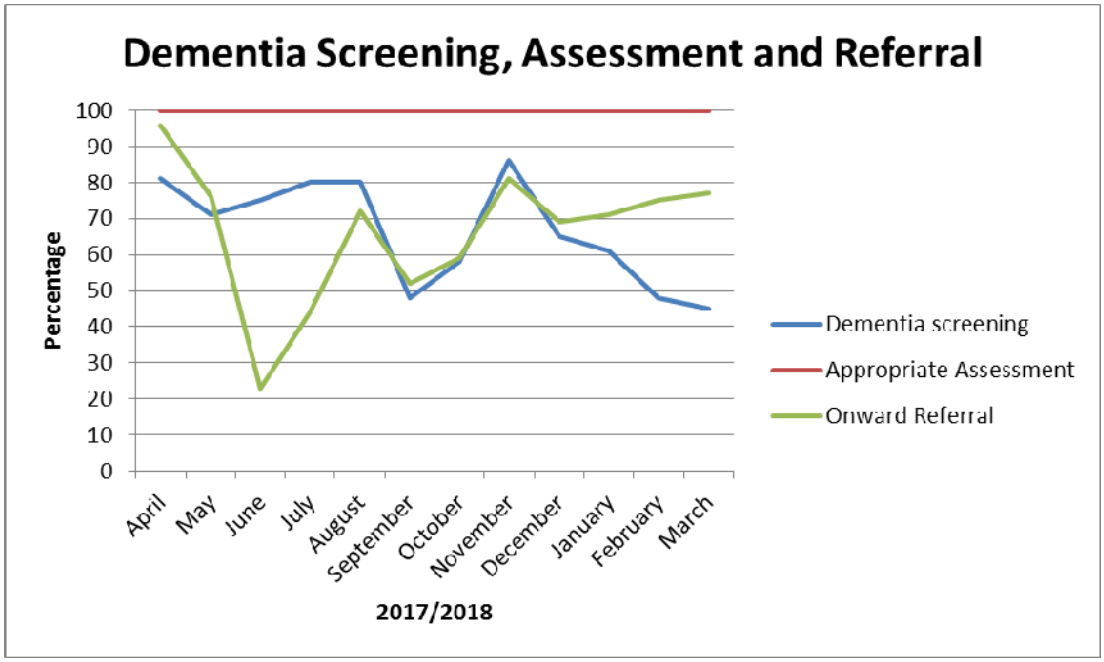
Dementia is caused when the brain is damaged by diseases, such as Alzheimer's disease or a series of strokes.

Around 850,000 people in the UK have dementia. By 2025 this number is expected to rise to over one million, with a projected rise to over 2 million by 2050

Successful screening, assessment and referral onto specialists can help patients to have access to services which may help the deterioration of the memory loss.

How did we perform?

Although the trust has consistently achieved the appropriate assessment indicator associated with this quality priority, the identification (screening) and subsequent onward referral to specialist services have not demonstrated the improvements that were hoped.



The successful appointment of a Dementia Nurse Practitioner to the Trust during 2017/18 has allowed for a much more comprehensive training ability for all staff, including consultants.

The Trust is aware that there are still significant improvements required in this quality priority and is developing a robust action plan, in conjunction with the nursing and medical teams to ensure that this can be delivered and sustained.

Patient Experience – Timely and Compassionate Response to Complaints

Goal 2017-2018:

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

Why is a timely response important?

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

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

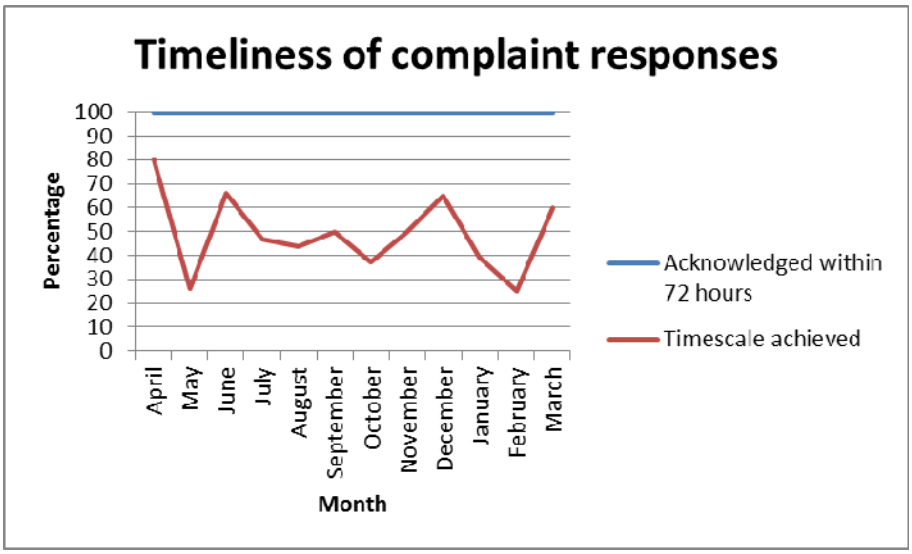
An effective complaint handling system provides three key benefits to an organisation:

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

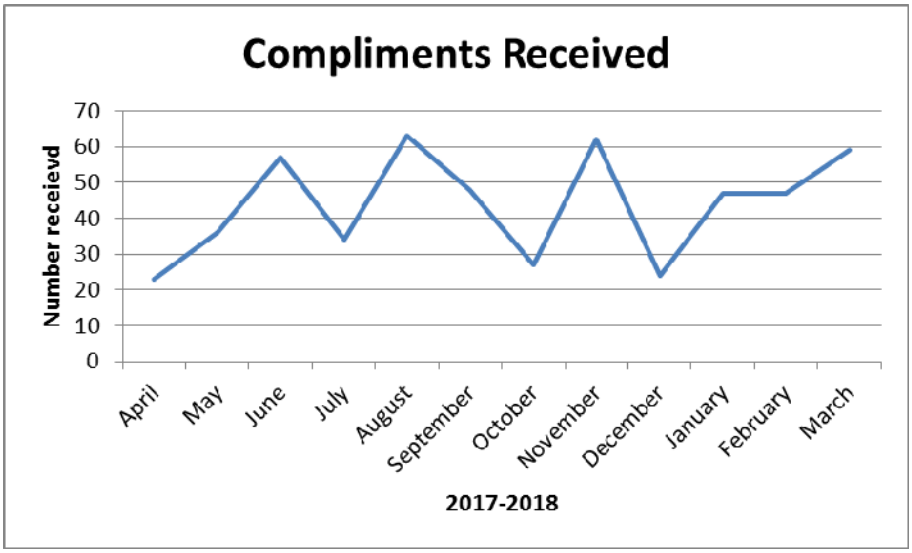
How did we perform?

Although a lot of work has been undertaken in the last year around improving the management of complaints, the results show that improvements in timeliness have not really been successful and have not been maintained.

Trust wide Performance



The introduction of a whole new governance process and in conjunction with a divisional restructure during 2017/18 has seen the development of new roles, such as the Divisional Head of Nursing and Quality, and the Quality Manager role. The internal Quality Committee has now requested that this be placed as an urgent priority for the divisions and management team to resolve and will continue to monitor this priority throughout the forthcoming year.



Patient Experience - Improving Accessibility of Information to our Patients

Goal 2017-2018:

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

Why is accessibility of information important?

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

People may need information presented in a particular way because of a particular impairment. Examples might include visual impairment, hearing impairment or a learning disability. It might be necessary to offer spoken versions, braille, phone calls, sign language, Makaton or easy read to make information accessible**.**

How did we perform?

The Trust retained the Department of Health's Information Standard certification scheme for another year following assessment. The Information Standard was implemented in 2013 to provide staff with a process for developing up-to-date, evidence based patient information. However, the Information Standard process has become increasingly onerous in recent years, making it more difficult for staff to quickly develop patient leaflets. For example, the Information Standard requires forms to be completed for each step of the leaflet writing process (pre-production, researching evidence, writing a draft, etc.) and requires multiple peer reviews and several patient panel reviews. Furthermore, the Information Standard offered no formal policy for the Trust to use and adopt leaflets written by other organisations.

In August 2017, the decision was made by the Patient Experience Group (Executive Director, Non Executive Director, Governors, staff and patient representatives) to replace the Information Standard with an in-house patient information scheme that better accommodated the needs and requirements of the Trust's new operational strategy and divisional restructure, which were implemented in April 2017. The new in-house leaflet scheme, called Information for Patients, introduced a new streamlined approval process so that departments may quickly adopt leaflets developed by other organisations, or write their own bespoke leaflets.

Amount of leaflets approved since implementation of new process = 193

This was done by clearly posting the steps of the new approval process on a Trust intranet page, reducing the number of required approval forms, and allowing all forms to be completed electronically. All Trust approved leaflets are now posted on the Trusts' public leaflet webpage so that

both patients and staff can access them. Staff are also asked to consider giving patients internet links to their leaflets rather than posting copies to them.

As all leaflets are now on the public webpage, further consideration is being given to purchasing ‘Browsealoud’. Browsealoud is an assistive software which makes websites accessible with screen reading & translation tools for visitors with dyslexia & reading difficulties, and people with mild visual impairments. It also offers spoken versions. Having Browsealoud enabled on our website would mean that those with learning difficulties or visual impairments could have a leaflet read aloud to them.

Risk Assessment Framework and Single Oversight Framework Indicators

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

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

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

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

Indicator	Standard	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Trend
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	92%	95.5%	94.9%	93.7%	92.1%	87.6%	85.3%	
Maximum ED waiting time of 4 hours from arrival to admission/transfer/ discharge	95%	96.5%	94.7%	94.9%	94.1%	93.2%	95.0%	
62 day wait for first treatment from an urgent GP referral for suspected cancer	85%	93.4%	88.4%	85.5%	81.7%	86.1%	80.2%	
62 day wait for first treatment following a NHS Cancer Screening Service referral	90%	96.8%	96.0%	98.2%	94.9%	94.9%	96.1%	
C-Diff hospital acquired cases (post 72 hours) due to lapses in care	<14	22	27	8	10	7	8	

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

HealthWatch

Local Healthwatch can choose to produce comments on Annual Quality Accounts on a voluntary basis.

This year, HealthWatch Dorset has chosen not to make comment.

DCHFT Lead Governor Commentary on the Trust Quality Report 2017-2018

Dorset County Hospital

Quality Report 2017-2018

15.5.2018

Thank you for asking me to comment on this year's Quality report as Lead Governor.

I found this to be an honest and open report based on data gathered over 2017-2018. It recognises the successes achieved and does not shy away from identifying areas where problems continue and need further attention. In view of this it seems sensible to continue with the same quality priorities into 2018-2019 as has been decided. The report is laid out clearly and identifies a plan for it to be monitored by the Trust Board, regularly throughout the year.

1) Falls resulting in severe injury or death – the background is well explained. The numbers have reduced, which is encouraging, although are too small for statistical analysis.
2) SHMI- The Oct 2016-2017 figures are just within the National average band. The reasons for this are complex and multifactorial and the Trust recognises the need to continue scrutiny and analysis of the data with the aim of getting the Trust out of the "higher than expected" range. Figure 2 requires alteration to identify the meaning of the horizontal lines and band. I note active plans with junior doctors and coders have been introduced to ensure definitive diagnoses and co-morbidities are recorded, and the rates have improved substantially.
3) Early treatment of sepsis- As a result of Trust intervention, a substantial improvement in sepsis screening rates and administration within an hour, have been recorded between 2016-2017 and 2017-2018. Further efforts are planned to get the rates into the >90% band.
4) Hospital volunteers- plans completed and about to be implemented.
5) Timeliness of Electronic discharge summaries- The rates are consistent although at 80% are disappointingly below the 90% target. Further work with Junior doctors and clerical staff is in progress to improve these results.
6) A broad programme to support Staff is well established and effective.
7) Dementia screening rates for >65 year olds are about 70% (target 90%) . The Trust has appointed a Dementia Nurse and anticipate improvements.
8) Timeliness of complaint responses – Acknowledgement within 72 hours runs at 100% and is excellent. The rates for full responses are very poor- under 30% in some months- and needs urgent attention. Plans are in place to improve this poor service.
9) Compliments received are consistently impressive. It is very good to see the heavy handed and demotivating bureaucracy surrounding patient information leaflets has been substantially reduced.

Dr DH Cove

Lead Governor

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Clinical Commissioning Group

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15 May 2018

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

Dear Nicky

Re: Quality Account 2017/18

Thank you for asking NHS Dorset Clinical Commissioning Group (CCG) to review and comment on your Quality Accounts for 2017/18. Please find below the CCG's statement for inclusion in the final document:

"Dorset CCG welcomes the opportunity to provide this statement on Dorset County Hospital NHS Foundation Trust's Quality Account. The CCG can confirm that it has no reason to believe this Quality Account is not an accurate representation of the performance of the organisation during 2017/18. The information contained within this Quality Account is consistent with information supplied to commissioners throughout the year and the CCG recognises the areas of strength described in the Quality Account and the areas which require further progress whilst awaiting an imminent Care Quality Commission (CQC) inspection.

During the year progress has been made in reducing the number of falls resulting in serious injury, improving support from hospital volunteers and promoting the health and wellbeing of patients and staff.

We recognise that in addition to the successes identified, the Trust has acknowledged that ambitions identified last year have not been achieved. In particular, improvement is required in relation to Electronic Discharge Summaries (EDS) and timely response to complaints. Further work is also required to provide assurance in relation to mortality surveillance. For that reason, the CCG are supportive of the Trust's decision to continue with the same quality priorities for 2018/19.

As Commissioners we look forward to working with the Trust during 2018/19 and we commend the fact that there is a willingness to work collaboratively to improve the experience for the population which the Trust serves. We look forward to the Trust demonstrating the improvements in patient care they will be applying over the coming year."

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

Yours sincerely

Vanessa Read
Director of Nursing & Quality

Dorset County Council

Official - sensitive

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Neal Cleaver
Deputy Director of Nursing
Dorset County Hospital
NHS Foundation Trust
Williams Avenue
Dorchester
Dorset
DT1 2JY

Date: 22 May 2018
My ref: DCH QA Letter 17/18
Your ref:

Dear Neal

Quality Account 2017/18

On behalf of the Dorset Health Scrutiny Committee, please find attached the commentary that we would like to submit following the opportunity to meet with the Dorset County Hospital NHS Foundation Trust over the past year, and in particular on 14 May 2018, to review the progress of your Quality Account.

Dorset Health Scrutiny Committee commentary for Dorset County Hospital NHS Foundation Trust, May 2018:

Three Members of the Dorset Health Scrutiny Committee are appointed annually to form a Task and Finish Group which meets twice per year with representatives of the Dorset County Hospital NHS Foundation Trust. These meetings provide an informal opportunity to discuss the progress being made by the Trust in improving quality and performance.

The annual Quality Account and Report for 2017/18 shared with the Group demonstrates another positive year for the Trust, and the Committee's representatives offer the following comments on items of particular interest or note:

- Members understand and support the decision to maintain the quality priorities identified in 2017/18 for the next year, in recognition of the need to undertake further work to improve performance in some areas and embed progress in others;
- With regard to patient safety, the reduction in the number of falls within the hospital resulting in severe harm or death was welcomed. Members were interested to hear of the on-going work to prevent as many falls as possible, including initiatives targeting community issues such as medicines reviews and the promotion of more stable day and night-time routines;
- With regard to mortality surveillance, Members acknowledged that the identification of the Trust as an outlier for excess deaths could be attributed to problems with data coding, and that a great deal of effort to address this is being undertaken;
- The failure to meet the targets regarding improving the recognition and early treatment of sepsis was disappointing, but it was helpful to hear the context in relation to recording processes. Members hope that measures implemented will deliver better performance going forwards;

- The work linked to clinical effectiveness to improve the support from hospital volunteers was very positive and the Trust is to be congratulated on securing the grant funding to implement this valuable project;
- It was disappointing to learn that progress in the timely dispatch of electronic discharge summaries is still not meeting targets. Members hope that the work to reduce backlogs and reviews of processes will help to improve the situation in the coming year;
- The focus on promoting the health and wellbeing of staff was recognised by Members as very important and the range of initiatives being developed was welcomed;
- With regard to patient safety, the deterioration in performance relating to dementia screening is a concern. It is hoped that the employment of the Dementia Nurse Practitioner will drive improvements forward, and Members welcome the continued focus on this area of work;
- The lack of improvement in timely response to complaints was also noted, but Members were pleased to hear that face to face meetings with complainants were proving constructive and that, with the support of a new governance process, action on this issue would continue;
- With regard to improving the accessibility of information, work to simplify the process of developing and publishing leaflets was highlighted. Members recognised the value of being able to react more quickly to the need for changes and noted the positive reaction from patients so far.

Overall, the Dorset Health Scrutiny Committee continues to find Dorset County Hospital NHS Foundation Trust to be open and cooperative in its meetings and communications with the Committee, and Members look forward to a continuation of this constructive relationship.

Yours sincerely

Ann Harris
Health Partnerships Officer

On behalf of Dorset Health Scrutiny Committee

CC:
Patricia Miller, Chief Executive, Dorset County Hospital NHS Foundation Trust
Cllr Bill Pipe, Chair Dorset Health Scrutiny Committee
Cllr Peter Shorland, Dorset Health Scrutiny Committee
Helen Coombes, Interim Director, Adult and Community Services
Nicky Lucey, Director of Nursing and Quality, Dorset County Hospital NHS Foundation Trust

Annex 2 Statement of Directors' Responsibility for the Quality Report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

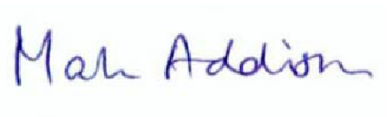
- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2017 to March 2018
    - papers relating to quality reported to the board over the period April 2017 to March 2018
    - feedback from commissioners dated 15th May 2018
    - feedback from governors dated 16th May 2018
    - feedback from local Healthwatch organisations dated 25th April 2018
    - feedback from Overview and Scrutiny Committee dated 22nd May 2018
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23rd May 2017
    - the latest national patient survey dated January 2018
    - the latest national staff survey dated March 2018
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2018
    - CQC inspection report dated 16/08/2016
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board



Mark Addison
Chairman
22 May 2018

Patricia Miller
Chief Executive
22 May 2018

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Dorset County Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Dorset County Hospital NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

1 percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

2 percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the *NHS foundation trust annual reporting manual* issued by NHS Improvement.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the *NHS foundation trust annual reporting manual* and supporting guidance
- the quality report is not consistent in all material respects with the sources specified in the "Detailed requirements for external assurance for quality reports 2017/18" issued by NHS Improvement in February 2018; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the "NHS foundation trust annual reporting manual" and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements 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 supporting guidance, 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 following:

- board minutes for the period April 2017 to May 2018
- papers relating to quality reported to the board since April 2017
- feedback from Dorset CCG (lead commissioner), dated May 2018
- feedback from governors, dated May 2018
- the Trust's complaints report published under regulation 18 of the Local
- Authority Social Services and NHS Complaints Regulations 2009, dated May 2017
- the 2017 national inpatient survey, dated January 2018
- the 2017 national staff survey
- Care Quality Commission inspection, dated August 2016
- the Head of Internal Audit's annual opinion over the Trust's control environment,

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Dorset County Hospital NHS Foundation Trust as a body, in reporting Dorset County Hospital NHS Foundation Trust's quality agenda, performance and activities.

Use of our report

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, 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 Dorset County Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- testing key management controls
- limited testing, on a selective basis, of the data used to calculate the indicator against 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 that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the “NHS foundation trust annual reporting manual” and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Dorset County Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and
- supporting guidance
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for external assurance for quality reports 2017/18; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Greg Rubins
For and on behalf of BDO LLP, appointed auditor
Southampton, UK
22 May 2018

Foreword to the Accounts

These accounts for the year ended 31st March 2018 have been prepared by Dorset County Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and comply with the annual reporting guidance for NHS Foundation Trusts within the Department of Health and Social Care Group Accounting Manual 2017/18.

Dorset County Hospital NHS Foundation Trust's Annual Report and Accounts are presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006.

Patricia Miller
Chief Executive
22 May 2018

Independent auditor's report to the Council of Governors and Board of Directors of Dorset County Hospital NHS Foundation Trust

Opinion on financial statements

We have audited the financial statements of Dorset County Hospital NHS Foundation Trust (the Trust) for the year ended 31 March 2018 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 notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and as interpreted and adapted by the 2017-18 Government Financial Reporting Manual as contained in the Department of Health and Social Care Group Accounting Manual 2017-18, and the NHS Foundation Trust Annual Reporting Manual 2017-18 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key Audit Matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Matter	How we addressed the matter in the audit
NHS revenue recognition NHS revenue is the most significant income stream for the Trust and is at most risk from material error and fraud. There is a risk that NHS revenue may be materially incomplete, inaccurate or inappropriately recognised. Refer to accounting policy (1.3), notes (3 and 4)	In responding to this risk, our audit procedures included: • We reviewed and considered the design and implementation of controls in place for the revenue system covering NHS income streams. • We reviewed the signed contracts for the Trust's significant commissioners and verified a sample of variations to these contracts. • We reviewed a sample of credit notes received after year end to ensure they were valid. • We ensured that all NHS income was accounted for in line with the revenue recognition policy adopted by the Trust. • We reviewed the outcomes of the national Intra-NHS Agreement of Balances process to ensure that all NHS income and receivables were confirmed as matched and for any mismatches exceeding £300k agreed to supporting evidence to corroborate the Trust's position and accounting treatment.
Management Override The Trust was originally forecast to achieve a deficit of £2.9m and Sustainability and Transformation Funding of £4.2m was contingent on this. There is an increased risk that the financial pressures arising from this situation will lead to management bias in accounting estimates and material misstatement in the financial statements.	In responding to this risk, our audit procedures included: • Heightened scepticism was applied throughout all of our testing, particularly around accounting estimates and significant judgements applied • Accounting policies were reviewed for evidence of inappropriate ones or failure of the trust to follow them. • Scrutinising the going concern assessment completed by management and those charged with governance • Challenging forecasts and assumptions used in the Trust's future financial plans and cash flow models. • Considering relevant findings of Internal Audit arising from their work relating to the financial position of the Trust and its financial management arrangements, and the overall Head of Internal Audit opinion.

	• Material estimates within the financial statements were reviewed and agreed to supporting calculations. Key assumptions included within the estimates were reviewed to confirm they are in line with industry expectations and historic results. • Material estimates were also reviewed for evidence of bias.
Financial stability and going concern The Trust recorded a deficit of £1.1m for the year ended 31 March 2017, and had forecast a deficit of £2.9m for the year ended 31 March 2018. The end result for 2018 was a surplus of £1.5m, however the Trust is forecasting deficits in 2018/19 and 2019/20. There is a significant risk to the Trust's ability to achieve financial sustainability in the medium term, with a potential impact on going concern. Refer to accounting policy (1.28)	In responding to this risk, our audit procedures included: • We considered the Trust's financial performance in the year to 31 March 2018, and achievement of control totals and planned Cost Improvement Programme schemes. • We reviewed the Trust's governance arrangements for financial and Cost Improvement Programme performance management. • We tested the feasibility of profit and loss and cashflow forecasts for the year ended 31 March 2019. • We reviewed the material estimates made in the accounts for evidence of bias.
Valuation of land and buildings Land and buildings are required to be held at fair value. There is significant judgement involved in determining the appropriate basis for each asset according to its degree of specialisation, as well as over the assumptions made in arriving at the valuation of the asset. (refer to accounting policy 1.8 and 1.9, note 14 and 15	In responding to this risk, our audit procedures included: • Agreement of underlying asset values: We considered the accuracy of the estate base data provided to the valuer to complete the desktop valuation to ensure it accurately reflected the Trust estate; • Assessment of the external valuer: We assessed the scope, qualifications and experience of Dorset County Hospital NHS Foundation Trust's valuer and the overall methodology of the valuation performed to identify whether the approach was in line with industry practice and the valuer was appropriately experienced and qualified to undertake the valuation; • Consideration of valuation assumptions: We critically assessed the assumptions used in preparing the desktop valuation completed of the Trust's land and buildings to ensure they were appropriate; • Impairment review: We considered how management and the valuer had assessed the need for an impairment across its asset base either due to a loss of value or reduction in future service potential. • Additions to assets: For a sample of assets added during the year we agreed the asset addition to invoice and confirmed that it was appropriate to capitalise the asset.

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements. We consider materiality to be the magnitude by which misstatements, including omissions, could influence the economic decisions of reasonable users that are taken on the basis of the financial statements. Importantly, misstatements below these levels will not necessarily be evaluated as immaterial as we also take account of the nature of identified misstatements, and the particular circumstances of their occurrence, when evaluating their effect on the financial statements as a whole.

Materiality for the financial statements as a whole was set at £3.26 million (2017 £3.19 million). This was determined with reference to the benchmark of gross expenditure (of which it represents 2%) (2017 - 2%) which we consider to be one of the principal considerations for the Council of Governors in assessing the financial performance and position of the Trust. Performance materiality is £2.285m.

We agreed with the Audit Committee to report to it all material corrected misstatements and all uncorrected misstatements we identified through our audit with a value in excess of £65,000 (2017-£64,000) in addition to other audit misstatements below that threshold that we believe warranted reporting on qualitative grounds.

Overview of the scope of our audit

The Trust operates as a single entity with no significant subsidiary bodies or other controlled undertakings. Accordingly our audit was conducted as a full scope audit of the Trust.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on information in the Remuneration and Staff Report

We have also audited the information in the Remuneration and Staff Report that is subject to audit, described in that report as being audited.

In our opinion the parts of the Remuneration Report to be audited have been properly prepared in accordance with requirements of the NHS Foundation Trust Annual Reporting Manual 2017-18.

Matters on which we report by exception – Use of Resources

Qualified conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, with the exception of the matter reported in the Basis for qualified conclusion on use of resources paragraph below, we are satisfied that, in all significant respects, Dorset County Hospital NHS FT put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion on use of resources

In 2017/18 the Trust met its control total agreed with NHS Improvement and qualified for income from the Sustainability and Transformation Fund. After taking account of £7.5 million Sustainability and Transformation Fund income the Trust reported a surplus of £1.5 million in its financial statements for the year ending 31 March 2018. The Trust has not yet, however, succeeded in addressing its underlying deficit and is forecasting a deficit of £1.3 million for 2018/19.

The deficit forecast for 2018/19 is evidence of weaknesses in proper arrangements to ensure it deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice we report to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the Annual Governance Statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual and is not misleading or inconsistent with other information that is forthcoming from the audit; or
- the Quality Report has been prepared in accordance with the detailed guidance issued by NHS Improvement.

We also report to you if:

- we have exercised special auditor powers in connection with the issue of a public interest report or we have made a referral to the regulator under Schedule 10 of the National Health Service Act 2006.

We have nothing to report in these respects.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibilities in respect of the Accounts, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors either intends to liquidate the Trust or to cease operations, or has no realistic alternative but to do so.

The Accounting Officer is also responsible for ensuring that the resources of the Trust are used economically, efficiently and effectively,

Auditor's responsibilities for the audit of the financial statements

In respect of our audit of the financial statements our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at: https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Auditor's other responsibilities

We are also required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of Dorset County Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Council of Governors of Dorset County Hospital NHS Foundation Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Council of Governors of Dorset County Hospital NHS Foundation Trust those matters we are required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the NHS Foundation Trust and the Council of Governors as a body, for our audit work, for this report or for the opinions we have formed.

Greg Rubins
For and on behalf of BDO LLP, Appointed Auditor
Southampton, UK
22 May 2018
BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127)

Statement of Comprehensive Income for the year ended 31st March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	156,742	152,103
Other operating income	4	23,817	19,100
Operating expenses	5	(176,440)	(169,575)
Operating surplus		**4,119**	**1,628**
Finance costs:			
Finance income	10	95	91
Finance expenses	11	(109)	(106)
PDC dividends charge		(2,612)	(2,693)
Net finance costs		**(2,626)**	**(2,708)**
Losses on disposal of assets	12	(20)	(42)
Surplus/(Deficit) for the year		**1,473**	**(1,122)**
Other comprehensive income			
Impairment of property, plant and equipment		(500)	(3,453)
Revaluation gains on property, plant & equipment		663	6,596
Total comprehensive income for the year		**1,636**	**2,021**

The notes on pages 156 to 186 form part of these accounts.

Statement of Financial Position as at 31st March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	5,638	4,347
Property, plant and equipment	15	94,088	92,110
Trade and other receivables	18.1	299	307
Total non-current assets		**100,025**	**96,764**
Current assets			
Inventories	17	3,019	3,026
Trade and other receivables	18.1	11,738	9,741
Cash and cash equivalents	19	2,493	4,427
Total current assets		**17,250**	**17,194**
Current liabilities			
Trade and other payables	20	(16,121)	(14,808)
Borrowings	21	(99)	(169)
Provisions	22	(43)	(88)
Other liabilities	23	(1,430)	(961)
Total current liabilities		**(17,693)**	**(16,026)**
Total assets less current liabilities		**99,582**	**97,932**
Non-current liabilities			
Borrowings	21	(4,807)	(4,889)
Provisions	22	(273)	(387)
Total non-current liabilities		**(5,080)**	**(5,276)**
Total assets employed		**94,502**	**92,656**
Financed by taxpayers' equity:			
Public dividend capital		85,317	85,107
Revaluation reserve		32,519	32,370
Income and expenditure reserve		(23,334)	(24,821)
Total taxpayers' equity:		**94,502**	**92,656**

The financial statements on pages 152 to 186 were approved by the Board on 22 May 2018 and signed on its behalf by:

Patricia Miller
Chief Executive
22 May 2018

Statement of Changes in Taxpayers' Equity

	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017	**92,656**	**85,107**	**32,370**	**(24,821)**
Surplus for the year	**1,473**	-	-	1,473
Transfers between reserves	-	-	(8)	8
Impairment losses on property, plant and	**(500)**	-	(500)	-
Net gain on revaluation of property, plant and	**663**	-	663	-
Public Dividend Capital	**210**	210	-	-
Transfer to the income and expenditure account in respect of assets disposed of	-	-	(6)	6
Taxpayers' equity at 31 March 2018	**94,502**	**85,317**	**32,519**	**(23,334)**
Taxpayers' equity at 1 April 2016	**90,635**	85,107	29,251	(23,723)
(Deficit) for the year	**(1,122)**	-	-	(1,122)
Transfers between reserves	**-**	-	(15)	15
Impairment losses on property, plant and	**(3,453)**	-	(3,453)	-
Net gain on revaluation of property, plant and equipment	**6,596**	-	6,596	-
Transfer to the income and expenditure account in respect of assets disposed of	**-**	-	(9)	9
Taxpayers' equity at 31 March 2017	**92,656**	**85,107**	**32,370**	**(24,821)**

The Revaluation Reserve consists of £32,519k (£32,370k at 31 March 2017) relating to property, plant and equipment.

Statement of Cash flows for the year ended 31st March 2018

	2017/18 £000	2016/17 £000
Cash flows from operating activities		
Operating surplus	4,119	1,628
Depreciation and amortisation	5,153	5,166
Impairments and reversals	(163)	(16)
Income recognised in respect of capital donations (cash and non-cash)	(753)	(377)
(Increase) in trade and other receivables	(1,947)	(4,180)
Decrease in inventories	7	117
Increase in trade and other payables	699	4,281
Increase in other liabilities	469	45
(Decrease) in provisions	(159)	(58)
Net cash generated from operations	**7,425**	**6,606**
Cash flows from investing activities		
Interest received	93	91
Purchase of intangible assets	(2,259)	(1,883)
Purchase of property, plant and equipment	(5,160)	(1,839)
Sales of property, plant and equipment	7	9
Receipt of cash donations to purchase capital assets	704	370
Net cash used in investing activities	**(6,615)**	**(3,252)**
Cash flows from financing activities		
Public dividend capital received	210	-
Capital element of finance lease obligations	(152)	(209)
Interest Paid	(97)	(97)
Interest element of finance lease obligations	(10)	(8)
PDC dividends paid	(2,695)	(2,631)
Net cash used in financing activities	**(2,744)**	**(2,945)**
(Decrease)/increase in cash and cash equivalents	**(1,934)**	**409**
Cash and cash equivalents at 1 April	4,427	4,018
Cash and cash equivalents at 31 March	**2,493**	**4,427**

Notes to the Financial Statements

1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2017/18 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHCS GAM permits a choice of accounting policy, the accounting policy that is judged to be the most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected.

The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting Convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Critical accounting judgements and key sources of estimation uncertainty

In the preparation of the financial statements, the Trust is required to make estimates and assumptions that affect the application of accounting policies and the carrying amounts of assets and liabilities. These estimates and assumptions are based on historical experience and other factors that are considered to be relevant. Actual outcomes may differ from prior estimates and the estimates and underlying assumptions are continually reviewed.

The key sources of estimation uncertainty which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities are:

Valuation of land and buildings
Land and buildings are included in the Trust's statement of financial position at current value in existing use. The assessment of current value represents a key source of uncertainty. The Trust uses an external professional valuer to determine current value in existing use, using modern equivalent asset value methodology and market value for existing use for non-specialised buildings.

Depreciation of property, plant and equipment and amortisation of computer software
The Trust exercises judgement to determine the useful lives and residual values of property, plant and equipment and computer software. Depreciation and amortisation is provided so as to write down the value of these assets to their residual value over their estimated useful lives.

1.2 Consolidation

1.2.1 Subsidiaries

Entities over which the Trust has power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves of the subsidiary are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not coterminous.

Subsidiarys that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

The Trust has established that, as it is the corporate trustee of Dorset County Hospital NHS Foundation Trust Charitable Fund, it effectively has the power to exercise control of this charity so as to obtain economic benefits. However the assets, liabilities and transactions are immaterial in the context of the Trust and therefore it has not been consolidated. Details of balances and transactions between the Trust and the charity are included in the related parties' notes.

The Trust has set up a wholly owned subsidiary during 2017/18. DCH Subco Ltd started trading with effect from 1st April 2018. No assets or transactions have taken place during 2017/18.

1.2.2 Joint Ventures

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the entity is a joint operator it recognises its share of assets, liabilities, income and expense in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The Trust entered into a joint venture with Interserve Prime to create a Strategic Estates Partnership during 2017/18. No assets or transactions have taken place during 2017/18.

1.3 Income

Income in respect of services provided is recognised when and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

At the year end, the Trust accrues income relating to activity delivered in that year.

Where income is received for a specific activity, which is to be delivered in the following financial year, this income is deferred.

The Trust received income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification form the Department of Work and Pensions Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

1.4 Expenditure on employee benefits

1.4.1 Short-term employee benefits

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

1.4.2 Pension costs

Payments to defined contribution pension schemes (including defined benefit schemes that are accounted for as if they were a defined contribution scheme) are recognised as an expense as they fall due.

NHS Pension Scheme: Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each

scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill health. The full amount of the liability for the additional costs are charged to operating expenses at the time the Trust commits itself to the retirement regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

The Foundation Trust does not have any employees that are members of the Local Government Superannuation Scheme and therefore, does not pay employer contributions into this scheme.

1.4.3 Termination Benefits

Staff termination benefits are provided for in full when there is a detailed formal termination plan and there is no realistic possibility of withdrawal by either party.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised to the extent that they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except when it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, plant and equipment

1.6.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually it cost at least £5,000; or
- collectively has a cost of at least £5,000 and individually a cost of more than £250;
- the assets are functionally interdependent, with broadly simultaneous purchase dates, which are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building includes a number of components with significantly different asset lives, e.g. hospital wings, then these components are treated as separate assets and depreciated over their own useful economic lives (UEL).

The component parts of each significant Trust building are depreciated as a group, as permitted by IAS 16, unless a component has a significantly different UEL and is deemed by the Trust to be significant, in which case it is depreciated separately over its own economic useful life.

1.6.2 Measurement

Valuation: All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Non-specialised buildings – market value for existing use
- land and specialised buildings – Modern equivalent asset value

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets

held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Bilfinger GVA carried out the Trust valuation as professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Until 31st March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. Indexation ceased from 1st April 2008. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment, which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

The valuation as reported in the Statement of Financial Position at 31st March 2018 was assessed by the valuer of Bilfinger GVA, based on a desktop valuation survey completed in March 2018 following a full valuation in April 2016.

Revaluation gains and losses: Revaluation gains are recognised in the revaluation reserve, except where; and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned; and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of other comprehensive income.

Impairments: In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits, or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) impairment charged to operating expenses; (ii) the balance in the revaluation reserve attributable to that asset before impairment.

An impairment that arises from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

1.6.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that the future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred

1.7 Intangible assets

1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; and where the cost of the asset can be measured reliably.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Expenditure on development is capitalised only where all of the following have been demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset is identified;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

1.8 Depreciation and amortisation

Freehold land is considered to have an infinite life and is not depreciated. Properties under construction are not depreciated until brought into use.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

The following table details the useful economic lives currently used for the main classes of assets:

Asset class	Useful economic life (years)
Buildings excluding dwellings	17 – 67
Dwellings	48 – 80
Plant & machinery	3 – 15
Information technology	4 – 10
Furniture & fittings	5 – 15
Intangible assets	5 – 15

Property, plant and equipment which have been re-classified as ‘held for sale’ cease to be depreciated upon the re-classification.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not

depreciated until the asset is brought into use or reverts to the Trust, respectively.

1.9 Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.10 De-recognition

Assets intended for disposal are reclassified as 'Held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not re-valued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.11 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'On-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent financial lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

1.12 Leases

1.12.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

1.12.2 Operating leases

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

1.12.3 Leases of land and buildings

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

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using the 'first-in first-out' formula. These are considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of that amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 0.7% in real terms, except for post-employment benefits provisions which use the HM Treasury's pension discount rate of 0.1% in real terms.

1.16 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 22.2 but is not recognised in the Trust's accounts.

1.17 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk-pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of any claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when the liability arises.

1.18 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, these are disclosed where an inflow of economic benefits is probable. The Trust currently has no contingent assets to disclose.

Contingent liabilities are not recognised, but are disclosed in note 25 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.19 Public dividend capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the 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 Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing net relevant assets.

In accordance with the requirement laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.20 Financial instruments and financial liabilities

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

1.20.1 Financial assets

Financial assets are classified into the following categories: Financial assets at fair value through income and expenditure; Held to maturity investments; 'Available for sale financial assets'; and 'Loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

The Trust did not during the period covered by these accounts hold any financial assets within the categories of: 'Financial assets at fair value through income and expenditure'; 'Held to maturity investments'; and 'Available for sale financial assets'.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.20.2 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Foundation Trust becomes party to contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has expired or been paid.

Financial liabilities are initially recognised at fair value.

1.20.3 Other financial liabilities

After initial recognition, all other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method except for

loans from the Department of Health which are carried at historic cost. The effective interest rate is the rate that discounts exactly estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Corporation Tax

The Trust is not liable to Corporation Tax for the following reasons:

Private patient activities are covered by section 14(1) of the Health and Social Care (Community Health and Standards) Act 2003 and not treated as a commercial activity and are therefore tax exempt; and

Other trading activities (including car parking and staff canteens) are ancillary to the core activities and are not deemed to be entrepreneurial in nature.

1.23 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the rates prevailing at that date. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However they are disclosed in Note 29 to the accounts in accordance with the requirements of the HM Treasury's Financial Reporting Manual.

1.25 IFRS adoption impact

The DHSC GAM does not require the following standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 identified for implementation in 2018/19, and the Government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration:

IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 15 Revenue from contracts with customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted

IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting period beginning on or after 1 January 2019.

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations, which is in line with guidance contained in the NHS GAM 2017/18.

1.26 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with general payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.27 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.28 Going concern

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

2. Segment analysis

The Trust has considered the requirements in IFRS 8 for segmental analysis. Having reviewed the operating segments reported internally to the Board, the Trust is satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- The nature of the products and services;
- The nature of the production processes;
- The type of customer for their products and services;
- The methods used to distribute their products or provide their services; and
- The nature of the regulatory environment.

The Trust therefore has just one segment, “healthcare”. Analysis of income by different activity types and sources is provided in note 3.

3. Income from patient care activities

Analysis by activity	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Elective income	30,050	29,108
Non-elective income	36,839	36,590
First outpatient income	11,164	11,359
Follow up outpatient income	15,467	16,487
A&E income	9,221	6,520
High costs drugs income from commissioners	11,412	11,443
Other NHS clinical income	41,166	39,177
Private patient income	896	939
Other clinical income	527	480
Total	**156,742**	152,103
Income from Commissioner Requested Services	151,956	147,856
Income from non-Commissioner Requested Services	4,786	4,247
Total	**156,742**	152,103

The A&E income includes income for Minor Injuries Units services in West Dorset, responsibility for which transferred to the Trust with effect from November 2016.

Commissioner-requested services are services which local commissioners believe should continue to be provided locally if any individual provider is at risk of failing financially. Any organisation providing a commissioner-requested service has to continue offering the service unless it can obtain agreement from NHS Improvement and the commissioners to stop. It cannot dispose of relevant assets used to provide the service without NHS Improvement consent and it must pay into a risk pool that will fund services in the event of financial failure.

Analysis by source	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
NHS - Foundation Trusts	250	194
NHS - Trusts	7	-
NHS - NHS England	27,870	29,997
NHS - CCGs	125,867	118,970
Local Authorities	1,249	1,478
NHS - Other	77	45
Non NHS - Private patients	896	939
Non NHS - Overseas patients	52	70
NHS Injury Scheme	449	385
Non NHS - Other	25	25
Total	**156,742**	152,103

NHS Injury Scheme income relating to the 2017/18 financial year is subject to a provision for doubtful debts of 22.84% (2016/17: 22.94%) to reflect expected rates of collection.

Overseas patient income for the year amounted to £52k (2016/17 £70k). Cash received amounted to £70k (2016/17 £42k) in respect of current and previous years' income. The amounts written off in respect of current and prior years amounted to £nil (2016/17 £nil).

4. Other operating income

	Note	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Research and development		939	933
Education and training		5,585	5,260
Education and training - notional income from apprenticeship fund		11	-
Received from NHS Charities: Physical assets		49	7
Received from NHS Charities: Cash donations		704	370
Received from NHS Charities: Contributions to expenditure		22	-
Non-patient care services to other bodies		6,715	5,024
Sustainability and Transformation Fund income		7,534	5,317
Staff recharges		371	398
Rental revenue from operating leases	6.2	98	12
Car parking		612	551
Catering		530	604
Pharmacy sales		61	83
Staff accommodation rentals		213	193
Estates recharges		27	41
IT recharges		15	23
Clinical excellence awards		149	181
Other income generation schemes		35	24
Other income		147	79
Total		**23,817**	19,100

5. Operating expenses

	Note	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Employee expenses	7.1	111,133	106,619
Employee expenses - Non-executive directors		126	122
Purchase of healthcare from NHS and DHSC bodies		6,395	4,571
Purchase of healthcare from non-NHS and non-DHSC bodies		3,012	3,406
Supplies and services - clinical (excluding drug costs)		16,615	17,090
Supplies and services - general		1,497	1,697
Drug costs		15,244	14,701
Inventories written down (net, including drugs)		40	32
Consultancy costs		378	364
Establishment		1,008	937
Premises - Business rates payable to Local Authorities		997	977
Premises - Other		5,939	5,926
Transport (business travel only)		463	445
Transport (other)		257	226
Depreciation on property, plant and equipment		4,320	4,401
Amortisation on intangible assets		833	765
Impairment net of (reversals)		(163)	(16)
Increase in provision for impairment of receivables		8	9
Change in provisions discount rate		(1)	15
External audit - statutory audit services		43	41
External audit - other assurance services		7	7
Internal Audit Costs - (not included in employee expenses)		89	110
Clinical negligence - NHS Resolution (premium)		6,536	5,814
Legal fees		231	82
Insurance		27	120
Research and Development		20	30
Training courses and conferences		457	433
Education and training - notional expenditure funded from apprenticeship fund		11	-
Rentals under operating leases - minimum lease	6.1	92	91
Car parking and security		3	3
Losses, ex gratia & special payments		36	4
Other services		204	121
Other		583	432
Total		**176,440**	169,575

6. Operating leases

6.1 As lessee

Payments recognised as an expense	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Minimum lease payments:		
Buildings	48	47
Other	44	44
Total minimum lease payments	**92**	91

Future minimum lease payments on buildings leases due:	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Not later than one year	29	43
Later than one year and not later than five years	115	-
Total	**144**	43

Future minimum lease payments on other leases due:	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Not later than one year	63	3
Later than one year and not later than five years	93	8
Total	**156**	11

6.2 As lessor

Rental recognised as an income	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Minimum lease payments:		
Land	98	12
Total minimum lease payments	**98**	12

Future minimum lease payments on land leases due:	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Not later than one year	-	18
Total	**-**	18

Future minimum lease payments on Buildings leases due:	**Year ended 31 March 2018 £000**	Year ended 31 March 2017 £000
Not later than one year	80	-
Later than one year and not later than five years	320	-
Later than five years	320	-
Total	**720**	-

7. Employee expenses and numbers

7.1 Employee expenses

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Employee expenses - Staff & executive directors	109,509	105,099
Employee expenses - Research and development staff	761	754
Employee expenses - Education and training staff	851	757
Redundancy	26	23
Early retirements	(14)	(14)
	111,133	106,619
Salaries and wages	89,029	85,406
Social security costs	8,309	7,928
Apprenticeship levy	426	-
Employer contributions to NHS Pension scheme	10,729	10,150
Pension cost - other	10	10
Agency and contract staff	3,005	3,395
Termination benefits	82	100
Less: Staff costs capitalised as part of assets	(457)	(370)
Employee benefits expense	**111,133**	106,619

Salaries and wages include the cost of amounts accrued in respect of holiday earned by employees due to their service, but not taken, as required under IAS 19.

The amount of Employer's pension contributions payable in the year ended 31 March 2018 was £10,739k (2016/17: £10,160k). Of this total, an amount of £915k (2016/17: £848k) was unpaid at the reporting date.

7.2 Retirement benefits

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

8. Retirements due to ill-health

During 2017/18 there were no cases (2016/17: 1 case) of early retirement from the Trust agreed on grounds of ill-health. The estimated additional pension liabilities of this ill-health retirement will be £nil (2016/17: £23k). The cost of ill-health retirements is borne by the NHS Business Services Authority – Pensions Division. This information has been supplied by NHS Pensions.

9. Salary and pension entitlement of directors and senior managers

9.1 Directors remuneration

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Directors remuneration - Salaries and wages	820	803
Employers pension contributions in respect of directors	91	87
	911	890

	Number	Number
The total number of directors to whom retirement benefits were accruing under:		
Defined contribution schemes	1	1
Defined benefit schemes	5	6

Detailed disclosures of the remuneration and pension entitlements of each director are set out on pages 29 to 34 of the Remuneration Report.

9.2 Multiple statement

All NHS Foundation Trusts are required to disclose the relationship between the total remuneration of the highest-paid director of the Trust and the median remuneration of the Trust's workforce. The remuneration of the highest paid director includes salary, performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions or the cash equivalent transfer value of pensions. The median remuneration of the workforce is the total remuneration of the staff member lying in the middle of the linear distribution of the total staff in the Trust, excluding the highest paid director. This is based on an annualised full time equivalent remuneration as at the reporting period date.

The banded remuneration of the highest-paid director in 2017/18 was £160,001 to £165,000 (2016/17: £155,001 to £160,000). This was 6.11 times (2016/17: 5.99 times) the median remuneration of the workforce, which was £26,614 (2016/17: £26,302). The highest paid Director was the Chief Executive.

The median remuneration of the workforce in 2017/18 falls within the salary range of a Foundation Doctor year 1 (2016/17 falls within the salary range of a Band 5 position under the Agenda for Change terms and conditions that apply to all non-medical staff). The actual salary of staff within each band is dependent on a number of factors, the most significant being the number of years they have served in that position.

In 2017/18 6 employees received remuneration in excess of the highest paid director (2016/17: 9 employees). Remuneration ranged from £167,600 to £189,200 (2016/17: £160,000 to £195,000). All employees receiving remuneration in excess of the highest paid director were medical consultants.

10. Finance income

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Interest on bank accounts	31	14
Interest on loans and receivables	64	77
Total	**95**	91

Interest on loans and receivables includes £64,000 (2016/17: £70,000) received in relation to a historic VAT claim.

11. Finance expenses

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Loans from the Department of Health	97	97
Finance Leases	12	8
Total interest expense	109	105
Unwinding of discount on provisions	-	1
Total finance expenses	**109**	106

12. Gains/(losses) on disposals

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Gains on disposal of other property, plant and equipment	4	3
Losses on disposal of other property, plant and equipment	(23)	(33)
Losses on disposal of intangible assets	(1)	(12)
Total (losses) on disposal of assets	**(20)**	(42)

13. Impairment of non-current assets

Impairment	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Unforeseen obsolescence	-	127
Changes in market price*	500	3,557
Reversal of impairments*	(163)	(247)
Total impairments	**337**	3,437

* Resulting from the revaluation of land and buildings as at 31 March 2018.

Total impairments have been charged/(credited) to the following lines in the Statement of Comprehensive Income.

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Operating expenses	(163)	(16)
Revaluation reserve	500	3,453
	337	3,437

14. Intangible assets

	Software licences 2017/18 £000	Software licences 2016/17 £000
Cost or valuation at 1 April	7,337	6,946
Additions - purchased	2,119	1,705
Additions - donated	6	-
Disposals	(149)	(1,314)
Cost or valuation at 31 March	**9,313**	7,337
Amortisation at 1 April	2,990	3,401
Provided in the year	833	765
Impairments charged to operating expenses	-	126
Disposals	(148)	(1,302)
Amortisation at 31 March	**3,675**	2,990
Net book value		
Purchased	5,613	4,313
Donated	25	34
Net book value total at 31 March	**5,638**	4,347

Software licences have been assigned asset lives of between 5 and 15 years. The total reported includes £nil (2017: £1,878k) of software under construction. This includes £nil (2017: £1,549k) of the Digital Patient Record (DPR) for the delivery of an electronic patient record system which was brought into use during 2017/18.

15. Property, plant and equipment

Assets utilised by the Trust under Finance leases arrangements are capitalised as part of property, plant and equipment under IFRS. The net book value of fixed assets held at the balance sheet date that were subject to a finance lease was £299k (2017: £506k).

The Trust's land and buildings were valued by external valuers as at 31 March 2018 on the basis of fair value, as set out in accounting policy note 1.6.2. The valuation was undertaken by Bilfinger GVA.

15.1 Property, plant and equipment, current year

Current year 2017/18	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	**112,251**	7,237	67,273	4,252	788	25,635	6,459	607
Additions - purchased	**5,251**	-	1,214	-	230	2,907	900	-
Additions - donations of physical assets	**43**	-	-	-	-	28	15	-
Additions - assets purchased from cash donations/grants	**704**	-	-	-	704	-	-	-
Impairments charged to revaluation reserve	**(1,110)**	-	(1,110)	-	-	-	-	-
Reversal of Impairments credited to operating expenses	**151**	159	(8)	-	-	-	-	-
Reclassification	**-**	-	236	-	(518)	-	282	-
Revaluation surpluses	**140**	208	(170)	102	-	-	-	-
Disposals	**(1,067)**	-	-	-	-	(790)	(272)	(5)
Cost or valuation at 31 March 2018	**116,363**	**7,604**	**67,435**	**4,354**	**1,204**	**27,780**	**7,384**	**602**
Depreciation at 1 April 2017	**20,141**	-	-	-	-	15,685	4,264	192
Provided in the year	**4,320**	-	1,089	56	-	2,272	875	28
Impairments recognised in revaluation reserve	**(610)**	-	(610)	-	-	-	-	-
Reversal of impairments recognised in other operating expenses	**(12)**	-	(12)	-	-	-	-	-
Revaluation surpluses	**(523)**	-	(467)	(56)	-	-	-	-
Disposals	**(1,041)**	-	-	-	-	(765)	(272)	(4)
Depreciation at 31 March 2018	**22,275**	**-**	**-**	**-**	**-**	**17,192**	**4,867**	**216**
Net book value as at 31 March 2018								
Owned assets	**89,349**	7,604	65,390	4,354	230	9,427	2,280	64
Finance lease	**299**	-	-	-	-	86	213	-
Donated assets	**4,440**	-	2,045	-	974	1,075	24	322
Total at 31 March 2018	**94,088**	**7,604**	**67,435**	**4,354**	**1,204**	**10,588**	**2,517**	**386**

15.2 Property, plant and equipment, pior year

Prior year 2016/17	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	**111,384**	8,942	64,960	1,915	245	26,054	8,673	595
Additions - purchased	**1,827**	-	535	-	510	509	262	11
Additions - leased	**305**	-	-	-	-	-	305	-
Additions - donations of physical assets	**7**	-	-	-	-	6	-	1
Additions - assets purchased from cash donations/grants	**370**	-	100	-	270	-	-	-
Impairments charged to operating expenses	**(110)**	(20)	(90)	-	-	-	-	-
Impairments charged to revaluation reserve	**(4,073)**	(1,833)	(2,240)	-	-	-	-	-
Reversal of Impairments credited to operating expenses	**241**	128	25	88	-	-	-	-
Reclassification	**-**	-	59	-	(237)	-	178	-
Revaluation surpluses	**6,193**	20	3,924	2,249	-	-	-	-
Disposals	**(3,893)**	-	-	-	-	(934)	(2,959)	-
Cost or valuation at 31 March 2017	**112,251**	**7,237**	**67,273**	**4,252**	**788**	**25,635**	**6,459**	**607**
Depreciation at 1 April 2016	**20,628**	-	-	-	-	14,199	6,263	166
Provided in the year	**4,401**	-	1,010	25	-	2,386	954	26
Impairments recognised in operating expenses	**(5)**	-	(6)	-	-	-	1	-
Impairments recognised in revaluation reserve	**(620)**	-	(620)	-	-	-	-	-
Reversal of impairments recognised in other operating expenses	**(6)**	-	(5)	(1)	-	-	-	-
Revaluation surpluses	**(403)**	-	(379)	(24)	-	-	-	-
Disposals	**(3,854)**	-	-	-	-	(900)	(2,954)	-
Depreciation at 31 March 2017	**20,141**	**-**	**-**	**-**	**-**	**15,685**	**4,264**	**192**
Net book value as at 31 March 2017								
Owned assets	**87,602**	7,237	65,218	4,252	518	8,397	1,896	84
Finance lease	**506**	-	-	-	-	232	274	-
Donated assets	**4,002**	-	2,055	-	270	1,321	25	331
Total at 31 March 2017	**92,110**	**7,237**	**67,273**	**4,252**	**788**	**9,950**	**2,195**	**415**

16. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements comprise:

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	452	679
Intangible assets	87	1,294
Total	**539**	1,973

17. Inventories

Current year 2017/18	**Drugs £000**	**Consumables £000**	**Other £000**	**Total £000**
Balance at 1 April	805	2,135	86	**3,026**
Additions	15,072	8,103	402	**23,577**
Inventories recognised as an expense in the period	(14,921)	(8,236)	(387)	**(23,544)**
Write-down of inventories recognised as an expense	(40)	-	-	**(40)**
Balance at 31 March	**916**	**2,002**	**101**	**3,019**

Prior year 2016/17	Drugs £000	Consumables £000	Other £000	Total £000
Balance at 1 April	722	2,330	91	3,143
Additions	14,491	5,444	626	20,561
Inventories recognised as an expense in the period	(14,376)	(5,639)	(631)	(20,646)
Write-down of inventories recognised as an expense	(32)	-	-	(32)
Balance at 31 March	805	2,135	86	3,026

The Trust does not currently operate a complete inventory management control system and is therefore, not able to separately evaluate any amount arising, from write-downs or losses, for inventories other than drugs.

18. Trade and other receivables

18.1 Trade and other receivables

	31 March 2018	31 March 2017
Current	**£000**	£000
NHS receivables	8,822	6,856
Trade receivables	71	275
Accrued income	346	289
Provision for impaired receivables	(92)	(84)
Prepayments	1,806	1,448
Interest receivable	3	1
PDC dividend receivable	40	-
VAT receivables	357	352
Other receivables	385	604
Total	**11,738**	9,741
Non-current		
Prepayments	114	125
Accrued income	185	182
Total	299	307
Grand Total	**12,037**	10,048

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by central government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Receivables past their due date but not impaired

	31 March 2018	31 March 2017
	£000	£000
By one to two months	482	416
By two to three months	32	100
By three to six months	452	160
By more than six months	380	468
Total	**1,346**	1,144

18.3 Receivables past their due date and impaired

	31 March 2018	31 March 2017
	£000	£000
By up to one month	-	3
By one to two months	2	3
By two to three months	10	7
By three to six months	38	28
By more than six months	429	407
Total	**479**	448

18.4 Provision for impairment of receivables

	31 March 2017 £000	31 March 2017 £000
Balance at 1 April	84	75
Increase in receivables impaired	8	9
Balance at 31 March	**92**	84

19. Cash and cash equivalents

	31 March 2018 £000	31 March 2017 £000
Balance at 1 April	4,427	4,018
Net change in year	(1,934)	409
Balance at 31 March	**2,493**	4,427
Made up of		
Commercial banks and cash in hand	5	5
Cash with Government Banking Service	2,488	4,422
Cash and cash equivalents	**2,493**	4,427

20. Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
NHS payables	2,827	1,923
Trade payables*	6,395	6,652
Capital payables	1,639	1,190
NHS Capital payables	206	-
Accruals	2,680	2,805
Other taxes payable	2,368	2,191
PDC payable	-	43
Accrued interest on DHSC loans	4	4
Accrued interest on Finance Leases	2	-
Total	**16,121**	14,808

* Trade Payables includes outstanding pension contributions of £1,524k (2017 £1,424k).

21. Borrowings

Current

	31 March 2018 £000	31 March 2017 £000
Obligations under finance leases	99	169
Total	**99**	169

Non-current

	31 March 2,017 £000	31 March 2,017 £000
Loans from Department of Health	4,600	4,600
Obligations under finance leases	207	289
Total	**4,807**	4,889

The Trust drew down a loan from the Department of Health against the receipt of future asset sales. This loan is repayable by 15th March 2021.

22. Provisions

	Current	
	31 March 2018	31 March 2017
	£000	£000
Pensions early departure costs	35	54
Other legal claims	8	34
Total	**43**	88

	Non-current	
	31 March 2018	31 March 2017
	£000	£000
Pensions early departure costs	273	387
Total	**273**	387

22.1 Provisions movement

	Total	**Pensions early departure costs**	**Legal and other claims**
	£000	**£000**	**£000**
At 1 April 2017	**475**	441	34
Change in discount rate	**(1)**	(1)	-
Arising during the year	**22**	21	1
Utilised during the year - accruals	**(10)**	(10)	-
Utilised during the year - cash	**(47)**	(35)	(12)
Reversed unused	**(123)**	(108)	(15)
At 31 March 2018	**316**	308	8
Expected timing of cash flows:			
Within one year	**43**	35	8
Between one and five years	**130**	130	-
After 5 years	**143**	143	-
Total	**316**	308	8

Provisions that are not expected to become due for several years are shown at a reduced value to take account of inflation.

Provisions shown under the heading 'Pensions early departure costs' have been calculated using figures provided by the NHS Pension Agency. They assume certain life expectancies. Provisions shown under the heading 'Legal claims' relate to public and employer liability claims. The liability claims amounts have been calculated using information provided by NHS Resolution and are based on the best information available at the balance sheet date

22.2 Clinical negligence liabilities

	31 March 2018	31 March 2017
	£000	£000
Amount included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust	81,409	71,333

23. Other liabilities

	31 March 2018 £000	31 March 2017 £000
Deferred income - goods and services	1,430	961
Total	**1,430**	961

24. Finance lease obligations

	Minimum lease payments		Present value of minimum lease payments	
	31 March 2018 £'000	31 March 2017 £'000	**31 March 2018 £'000**	31 March 2017 £'000
Gross lease liabilities	**322**	483	**301**	459
of which liabilities are due				
not later than one year	108	180	105	176
later than one year and not later than five years	214	303	196	283
Finance charges allocated to future periods	(16)	(25)	(15)	(25)
Net lease liabilities	**306**	**458**	**286**	**434**
of which liabilities are due				
not later than one year	99	169	96	164
later than one year and not later than five years	207	289	190	270
	306	**458**	**286**	**434**

All finance lease obligations disclosed above relate to plant and machinery.

25. Contingencies

Contingent liabilities	**31 March 2018 £000**	31 March 2017 £000
Risk pooling*	24	24
Employment tribunal and other employee related litigation	77	-
Early retirement	1	3
Injury benefits	1	19
Total	**103**	46

* Risk pooling is in respect of employer and public liability incidents for which claims have been made against the Trust. The contingent liabilities have been calculated using information provided by NHS Resolution. Provisions relating to these cases are included in Note 22.

26. Financial instruments

26.1 Financial assets

	31 March 2018	31 March 2017
Loans and receivables	**£000**	£000
Trade and other receivables with NHS and DH bodies	8,822	6,856
Trade and other receivables with other bodies	497	908
Cash and cash equivalents at bank and in hand	2,493	4,427
Total at 31 March	**11,812**	12,191

The financial assets consist of the financial element of trade and other receivables (Note 18.1) and cash and cash equivalents at bank and in hand (Note 19).

26.2 Financial liabilities

	31 March 2018	31 March 2017
	£000	£000
Borrowing excluding finance lease and PFI contract	4,600	4,600
Obligations under finance lease	306	458
Trade and other payables with NHS and DH bodies	3,028	1,923
Trade and other payables with other bodies	8,831	8,826
Provisions under contract	316	475
Total at 31 March	**17,081**	16,282
Maturity of		
In one year or less	12,001	11,006
In more than one year but not more than two years	121	133
In more than two years but not more than five years	4,816	4,949
In more than five years	143	194
	17,081	16,282

The financial liabilities consist of the financial element of trade and other payables (Note 20), plus current and non-current borrowings (Note 21) and provisions (Note 22.1) excluding legal costs.

26.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions and Policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

26.3.1 Currency risk

The Trust is a UK based organisation with no overseas operations. The vast majority of its income, expenses, assets and liabilities are denominated in sterling, and therefore it has low exposure to currency risk.

26.3.2 Interest rate risk

The Trust's exposure to interest rate risk is limited to the rate of interest it earns on short-term cash deposits placed with the National Loans Fund and its cash balances with the Government Banking Service. All of the borrowings of the Trust are at fixed rates of interest.

The Trust earned interest of £31,000 (at an average rate of approximately 0.2%) during 2017/18. An increase in interest rates of 0.5% would increase interest earned by approximately £64,000.

26.3.3 Credit risk

The majority of the Trust's trade and other receivables are due from other NHS bodies that are funded by central government. As a result, the Trust has a low credit risk profile. Exposures as at 31 March are disclosed in the Trade and other receivables note.

The Trust has a credit control policy and actively pursues unpaid debts, utilising the services of a debt collection agency for certain older debts. The Trust does not enter into derivative contracts.

26.3.4 Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from internally generated funds, or from facilities made available from Government under an agreed borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has a surplus of £1.5m in the current financial year and has a cash balance of £2.5m. Therefore, there is minimal risk to payables.

27. Events after the reporting period

There have been no significant post balance sheet events requiring disclosure.

28. Related party transactions

Dorset County Hospital NHS Foundation Trust is an independent public benefit corporation as authorised by NHS Improvement in their Terms of Authorisation.

None of the Trust's Directors, senior managers, or parties deemed to be related to them, has undertaken any material transactions with Dorset County Hospital NHS Foundation Trust.

The Department of Health and Social Care is regarded as the ultimate parent of the Trust. During the year the Foundation Trust has had a significant number of transactions with entities for which the Department of Health is regarded as the ultimate parent.

Central and Local Government and NHS entities, with which the Foundation Trust had transaction totals exceeding £500,000 for the year, are listed in the following table.

	Income in year to 31 March 2018 £000	**Expenditure in year to 31 March 2018 £000**	**Receivables at 31 March 2018 £000**	**Payables at 31 March 2018 £000**
Department of Health	30	7	10	4,604
Dorset County Council	1,343	285	26	252
Dorset Healthcare NHS Foundation Trust	1,942	4,513	229	1,623
Health Education England	5,913	15	14	-
HM Revenue and Customs - Tax & NI	-	8,735	-	2,368
NHS Blood and Transplant	6	647	-	15
NHS Dorset Clinical Commissioning Group	120,815	242	-	859
NHS England - Core	7,964	305	4,820	81
NHS England - Wessex Local Office	3,577	-	221	-
NHS England - South Central Local Office	883	-	-	83
NHS England - Wessex Commissioning Hub	23,049	-	1,680	-
NHS Resolution	-	6,644	-	-
NHS Pension Scheme	-	10,729	-	1,524
NHS Somerset Clinical Commissioning Group	2,218	-	-	5
Poole Hospital NHS Foundation Trust	1,429	1,125	289	501
University Hospital Southampton NHS Foundation Trust	871	260	267	28
Somerset Partnership NHS Foundation Trust	509	-	54	-

The payables included above in respect of HM Revenue and Customs and NHS Pension Scheme include both employee and employer contributions. The expenditure figures for these organisations are only in respect of employer contributions.

The Trust receives revenue payments and contributions to the cost of non-current assets from the Dorset County Hospital NHS Foundation Trust Charitable Fund, of which the Foundation Trust is the corporate trustee.

Transactions with Dorset County Hospital NHS Foundation Trust Charitable Fund:	**31 March 2018 £000**	31 March 2017 £000
Contributions from the Charity to non-current assets	753	277
Contributions from the Charity to expenditure	22	-
Administration costs charged to the Charity	22	22

29. Third Party Assets

The Trust holds cash and cash equivalents which relate to monies held on behalf of patients. These amounts have been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018 £000	31 March 2017 £000
Monies held on behalf of patients	**-**	1

30. Losses and special payments

The total costs included in this note are on a cash basis and may not reconcile to the amounts in the notes to the accounts, which are prepared on an accruals basis.

	Number of cases		**Total value of cases**	
	31 March 2018 Number	31 March 2017 Number	**31 March 2018 £'000**	31 March 2017 £'000
Losses;				
Bad debts and claims abandoned in relation to:				
private patients	**-**	1	**-**	-
other	**1**	1	**5**	-
Damage to buildings and property due to:				
stores losses	**1**	1	**40**	32
Special Payments;				
Compensation under court order or legally biniding arbitration award	**2**	-	**31**	-
Ex-gratia payments in respect of:				
loss of personal effects	**19**	19	**5**	4
other	**5**	4	**-**	1
	28	26	**81**	37

31. Limitation on auditor's liability

The limitation on the Trust's auditor's liability is £0.5million (2016/17: £0.5million).

32. Pooled Budget – Equipment for Living Partnership

The Trust, via Dorset CCG, contributes towards a pooled budget arrangement which started on the 1st April 2015. This is hosted by Bournemouth Borough Council to provide equipment for Living Partnership. This replaced the Integrated Equipment Service hosted by Dorset County Council which ceased on the 31st March 2015.

Payments are included in note 5 – Operating expenses under heading Purchase of healthcare from NHS and DHSC bodies. The Trust contributed £187k in 2017/18 (£185k 2016/17). This forms part of the Dorset CCG total included in the table below.

The below disclosure is based on month 12 information provided by Bournemouth Borough Council and it should be noted that these figures are un-audited.

	Year ended 31 March 2018	Year ended 31 March 2017
Funding	**£000**	£000
Bournemouth Borough Council	637	637
Borough of Poole	592	592
Dorset County Council	1,313	1,296
Dorset CCG	5,058	5,058
Partner Contributions (excluding management costs)	7,600	7,583
Partner Allocation: Local Authority	33	122
Partner Allocation: CCG	66	247
Total Funding	**7,699**	7,952
Expenditure		
Integrated Community Equipment Store		
Actual Spend to March	(7,699)	(7,952)
Total Expenditure	**(7,699)**	(7,952)
Total Surplus at 31 March	**-**	-

33. Other Financial Commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018	31 March 2017
	£000	£000
not later than 1 year	2,546	3,116
after 1 year and not later than 5 years	465	1,075
Total	**3,011**	4,191