University Hospitals Dorset NHS Foundation Trust

Interim Board of Directors – Part One

25 November 2020 13:15 – 15:15

Via Microsoft Teams

(Link to join meeting can be found in Outlook Diary Appointment)

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PART 1
HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust held in public will commence at 13:15 on Wednesday 25 November 2020 via Microsoft Teams.

If you are unable to attend please notify the Company Secretary's Team, telephone 0300 019 2980

David Moss
Chairman

Please note that mobile devices and laptops may be in use during the meeting to access papers, record actions and notes as appropriate

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AGENDA – PUBLIC MEETING

13:15	1	Apologies for Absence:		
	2	Declarations of Interest		
	3	Patient Story		
	4	For Accuracy and to Agree: Joint Part 1 Minutes of the PHFT and RBCHFT Boards of Directors Meeting held on 30 September 2020		Chairman
	5	Matters Arising – Action List		Chairman
13:35	6	Chief Executive's Report		CE
	7	**RISK**		
	7.1	Update on Covid-19 and Phase 3 Recovery		CNO/COO
13:55	**8**	**QUALITY AND PERFORMANCE**		
	8.1	For approval	Winter Plan/Phase 2 Covid Plan	COO
	8.2	For discussion	Integrated Quality, Performance & Workforce Report	Chief Officers
	8.3	For information	Mortality Report: Q2	CMO
	8.4	For discussion	Freedom to Speak Up Report	FTSUG
14:40	**9**	**STRATEGY AND TRANSFORMATION**		
	9.1	For information	Update on Transformation (to include Estates)	CSO

14:50	**10**	**GOVERNANCE**		
	10.1	For approval	Charitable Funds Expenditure over £250k	CFO
	10.2	For approval	Poole Charity Accounts 2019/20 and Letter of Representation	CFO
	10.3	For approval	Bournemouth Charity Accounts 2019/20 and Letter of Representation	CFO
	11	Questions from the Appointed Governors and Public arising from the agenda Appointed Governors and Members of the public are requested to submit questions relating to the agenda by no later than 22/11/2020 to carrie.stone@uhd.nhs.uk		
	12	Any Other Business		
	13	Key points of communication		
	14	Date and Time of Next Meeting: Wednesday 27 January 2021 at 13:15 via Microsoft Teams		
	15	2021 Meeting Dates: 27 January 2021; 31 March 2021; 26 May 2021; 28 July 2021; 29 September 2021; 24 November 2021.		
	16	RESOLUTION REGARDING PRESS, PUBLIC AND OTHERS To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.		
15:15	**17**	NB: A glossary of abbreviations that may be used in the Board of Directors papers will be found at the back of the Part 1 papers.		

AGENDA – PRIVATE MEETING

15:30	**18**	Welcome & Apologies for Absence:		Chairman
	19	Declarations of Interest		Chairman
	20	**APPROVAL OF MINUTES AND ACTIONS:**		
	20.1	For Accuracy and to Agree: Part 2 Minutes of meeting held on 28 October 2020		Chairman
	20.2	Matters Arising – Action List		Co Sec
15:40	**21**	**QUALITY, PERFORMANCE & RISK**		
	21.1	For information	Update on Covid Outbreak at Poole Hospital	CNO
	21.2	For information	Serious Incident Report	CMO
	21.3	For information	Risk Registers: New Red Risks	CNO

	22	**STRATEGY AND TRANSFORMATION**		
	22.1	For information	Draft UHD HIP2 Capital Project SOC	CSO
	22.2	For information	Update on Charities Merger (*verbal*)	CFO
	23	**GOVERNANCE**		
	23.1	For approval	2nd Linac	CFO
	23.2	For approval	Clinical Waste Services Recommendation Report	CFO
	23.3	For approval	Stour Building Business Case	CSO
	23.4	For approval	Roche Managed Laboratory Services MES	CFO
	23.5	For approval	Approved Framework Contractors List for Repairs and Maintenance	CFO
	23.6	For information	Update on the Joint Investment Committee	CFO
	23.7	For information	Board Committees: Exception Reports	Non-Exec Chairs
	24	Any other business		
	24.1	Key points of communication to staff		
	25	Board Reflection on the Current Meeting: • What has gone well; • What do we need to do more of; • What do we need to do less of.		
	26	Date and Time of Next Private Board Meeting: Interim Board of Directors Part 2 Meeting on Wednesday 27 January 2021 at 15:30 at via Microsoft Teams.		
17:00	**27**	Close of meeting.		

*Late paper

JOINT MEETING OF THE BOARD OF DIRECTORS PART 1 – PUBLIC MEETING

Minutes of the meeting of the Poole Hospital NHS Foundation Trust (PHFT) and the Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust (RBCH) Boards of Directors held on Wednesday 30 September 2020 at 09:00 via Microsoft Teams.

Present:	Mr David Moss	Joint Interim Chairman
	Ms Karen Allman	Director of Human Resources (RBCH)
	Mrs Jacqueline Cotgrove	Director of Workforce and Organisational Development (Poole)
	Mr Pankaj Dave	Non-Executive Director (RBCH)
	Mrs Debbie Fleming	Joint Interim Chief Executive
	Mr Philip Green	Non-Executive Director (Poole)
	Prof Christine Hallett	Non-Executive Director (RBCH)
	Mr Alex Jablonowski	Non-Executive Director (RBCH)
	Mr John Lelliott	Non-Executive Director (RBCH)
	Ms Deborah Matthews	Director of Organisational Development (RBCH)
	Mr Mark Mould	Chief Operating Officer (Poole)
	Mr Stephen Mount	Non-Executive Director (Poole)
	Dr Alyson O'Donnell	Medical Director (RBCH)
	Mr Pete Papworth	Joint interim Director of Finance
	Mr Iain Rawlinson	Non-Executive Director (RBCH)
	Mr Richard Renaut	Chief Strategy & Transformation Officer
	Prof Cliff Shearman	Non-Executive Director (RBCH)
	Mrs Paula Shobbrook	Director of Nursing & Midwifery (RBCH)
	Mrs Caroline Tapster	Non-Executive Director (Poole)
	Dr Matt Thomas	Acting Medical Director (Poole)
	Mr David Walden	Non-Executive Director (Poole)
	Mr Nick Ziebland	Non-Executive Director (Poole)
In Attendance:	Mr James Donald	Head of Communications (RBCH)
	Ms Claire Rogers	Group Director of Nursing, Specialties (item 3)
	Mr M Ramchandani	Clinical Director: Ophthalmology (RBCH) (item 3)
	Mr M Stevens	Patient Story (item 3)
	Mr M Oborza	Deputy Clinical Leader (item 3)
	Mrs Carrie Stone	Company Secretary (Poole)
	Mr Mike Weaver	Interim Assistant Company Secretary (minute taker)

BOD 146/20 Apologies for Absence

Mr Moss welcomed everyone to the public Board of Directors meeting.

Apologies for absence were received from Dr Calum McArthur, Non-Executive Director (Poole), Mrs Patricia Reid, Director of Nursing (Poole) and Ms Donna Parker, Interim Chief Operating Officer (RBCH).

BOD 147/20 Declarations of Interest

There were no declarations of interest noted.

BOD 148/20 Patient Story

Mr Moss welcomed Mr Ramchandani, Clinical Director Ophthalmology (RBCH) and Mr Stevens to present the patient story.

Mrs Shobbrook welcomed Mr Oborza, Deputy Clinical Leader and Ms Rogers, Group Director of Nursing, Specialties. Mrs Shobbrook invited Mr Stevens to speak of his experience with the Ophthalmology service at the Royal Bournemouth Hospital.

Mr Stevens reported he received excellent care throughout his stay in hospital. Mr Stevens was aware the Trust was running at a fraction of its normal capacity due to social distancing restrictions and he described his concerns about attending hospital. However, once he was in hospital, he had no fears whatsoever. The care was excellent and the social distancing measures were superbly observed. Mr Stevens expressed his thanks to all staff who had been very professional and did their best in very difficult circumstances. Mr Stevens reported he felt very well looked after and would have no hesitation recommending the hospital.

Mr Moss thanked Mr Stevens for his account of his experience of the Ophthalmology service and invited Mr Ramchandani to respond. Mr Ramchandani thanked the Board for the opportunity to talk about the challenges faced by the unit during Covid-19 and described the background to Mr Stevens' presentation and treatment. The case discussed today served to highlight the importance of maintaining a service, even outside of a pandemic in order to ensure the Trust may prioritise patients who were at risk of losing their sight.

Mr Oborza described the changes made on the Eye ward during Covid-19. Members of the Board were invited to visit the unit to see the changes that have been made.

Mr Moss expressed his appreciation for the work undertaken by all staff in the Ophthalmology service. Ms Rogers also expressed her thanks to the Eye unit team. Dr O'Donnell noted that the Ophthalmology team are a very specialist, relatively isolated team within the hospital but they were incredibly corporately joined up and notable for their response and support in times of winter pressures and other challenges in the hospital.

Mrs Tapster thanked Mr Stevens for attending today's Board meeting. Based on his experience as a patient with an underlying health condition Mrs Tapster asked if there was anything more the Trust could be doing to encourage people to come to hospital. Mr Stevens suggested the Trust should ensure that patients are aware of all the changes the Trust had made to make everyone feel safe and even share some statistics that show the very low number of patients that had tested positive for Covid-19. Mrs Shobbrook thanked Mr Stevens and the team for sharing his story at today's meeting that demonstrated how the Trust had worked to ensure a safe service for all patients that attend hospital. The prioritisation work undertaken by the team was very important, and served to highlight the need to manage the balance between capacity, demand and risk during this time.

Mr Moss thanked Mr Ramchandani and Mr Orboza on behalf of the Board.

BOD 149/20 For Accuracy and to Agree: Part 1 Minutes of the Board Meeting held on 29 July 2020

Mr Gill noted an amendment to minute number 141/20: noting that the Trust achieved 44 points of the toolkit and was only not compliant to 95% for mandatory training compliance. References to the "DSB" amended to "DPST". Subject to these amendments the minutes were AGREED as a correct record of the meeting.

BOD 150/20 Matters Arising – Action List

It was NOTED and AGREED that all matters arising unless subject this or future agendas had been executed.

BOD 151/20 Chief Executive's Report

Mrs Fleming presented her report with the key points noted as follows:

- There were currently three patients in the hospital with Covid-19, two in PHFT and one in RBCH and no patients with Covid-19 in Intensive Care. The position was kept under close review and it was expected that going into the winter period the number of Covid-19 patients in the hospital would change. The Trust had learnt a lot in its response to the pandemic. Covid-19 was now included in control of infection reporting. The three priorities for the Trust going forward will be to provide safe care for patients, ensure Covid-19 becomes an intrinsic part of winter planning and ensuring all staff were kept safe and felt supported.
- There has been a great deal of media coverage recently relating to problems experienced by members of the public in accessing tests for Covid-19, and clearly this was causing a great deal of concern, both nationally and locally. Mrs Fleming set out arrangements for Covid-19 testing that include Pillar One testing undertaken by the Trust for its own patients and staff and Pillar Two testing available for the public and other key workers through the Creekmoor site, drive through and mobile sites. The Trust had expanded its testing facilities significantly over the last few months including the introduction of rapid testing. Testing within the hospital can be undertaken in 2 hour, 4 hours, 12 hours or 24 hours. Patients attending the Emergency Department would receive very rapid testing, whilst patients attending for planned care can receive a test two days before their attendance. Work was also underway at a national level to provide better information for the public, to assist them in deciding when it was appropriate to request a test for Covid-19.
- The differential impact of Covid-19 on specific members of the local population and staff had been highlighted. It was the role of all members of the Board to promote inclusion and tackle persistent health inequalities. Mr Papworth and Prof Hallett would be the colleagues to champion and increase the scale and pace of organisational efforts. The Director of Organisational Development, Ms Matthews, would be working alongside them to define their role and the expectations, in line with national guidance and best practice.
- The past few weeks have been extremely busy as the team continued working to take forward an extensive capital programme
- The Trust was working to understand the revised financial allocations and payment guidance effective from 1 October that set out in detail the changes relating to system funding envelopes, and how block contracts and national top-ups would operate until the end of the financial year. The Trust was undertaking a further internal process to re-evaluate current expenditure and confirm its recovery plans. This would allow the Trust to prioritise funding for the remainder of the financial year to ensure maximum benefit for our patients.
- As members would be aware, the UK exited the European Union on the 31st January 2020 and remains in a transition period. From the 1st January 2021, the UK will regain its political and economic independence and can start new trading relationships with the EU and rest of the world. Whilst the Trust has been focusing on Covid-19, this remains an extremely important matter, with a number of key risk areas for University Hospitals Dorset (UHD) for which there are plans in place.
- On 14 September 2020, the Strategic Electronic Patient Record (SEPR) project board agreed to close the project that had been running for 4 years to migrate the RBCH clinical staff from a legacy EPR (eCAMIS Clinical Viewer) to Graphnet Carecentric which had been in place in Poole since 2002. The completion of this four-year project was a huge achievement. Mr Gill paid tribute to a number of staff involved in the project.

BOD 151/20 Chief Executive's Report

- Despite disruption associated with Covid-19, PHFT and RBCHFT went ahead with virtual Annual Members' meetings for each Trust earlier in the month.
- This was the last day that PHFT and RBCHFT would operate as individual organisations. The two Trusts would officially merge on 1 October 2020.

Mr Jablonowski expressed his congratulations to Mr Gill and his team for completing the SEPR project.

Mr Green asked Mrs Fleming to explain how agreement would be reached should there be any disagreement over the allocation of finances in the ICS. Mr Moss suggested the question could be taken when Mr Papworth updated the Board on the month 5 financial performance.

Members of the Board watched a short video that showed staff reflecting on the opportunities associated with transformation of services following the formation of University Hospitals Dorset NHS Foundation Trust (UHD).

The report was NOTED.

BOD 152/20 Integrated Quality, Performance and Workforce Report – August 2020

Mr Mould presented a report on the operational performance of the combined Trust during August 2020 that included recovery plans and expressed his thanks to Ms Parker whilst working as Interim Chief Operating Officer at the Bournemouth site during what had been a very busy time for the Trust. The key points were noted as follows:

- The report should be understood in the context of the environment the Trust had been working in that had had an effect on operational performance, quality and workforce. Covid-19 had had a significant impact on all three sites. The requirements to don and off Personal Protective Equipment (PPE) had slowed down the process of care delivery. In order to maintain social distancing, there were 53 closed beds at PHFT and circa 60 closed beds at RBH.
- There was limited swabbing capacity at the front door to ensure patients were on the right pathway at the right time. Whilst the situation was improving, current swabbing capacity was 30 tests on each site per day and so the Trust needed to ensure it utilised limited swabbing capacity very well. There was also a delay in swab turnaround times.
- As it was holiday season in August the ability to backfill workforce gaps was difficult.
- There was an increasing number of medically ready to leave patients in the organisations as care in the community became more difficult to source.
- Diagnostics Waiting Times and Activity (DM01): performance was reported at 80% in August and performance in September is reported as 90%. Areas of challenge included Endoscopy and Echocardiography, although measures to increase capacity had led to improvement in performance.
- Cancer performance in Dorset was doing well.
- The number of 104 day back stops had significantly reduced and a "harm" review for all patients had been undertaken by relevant clinicians.
- Referrals had returned to normal levels. As this happened there were some patients who had entered the pathway past 62 days and the Trust was working through the impact of this.

BOD 152/20 Integrated Quality, Performance and Workforce Report – August 2020

- RTT: performance improved in August 2020 from 41% to 49% against a national target of 90%. The most significant challenge was the increase of patients waiting over 52 weeks. In response the Trust undertaken a clinical validation exercise of the waiting list. In addition, the Trust was required to undertake a national validation exercise by the end of October 2020. The Trust was continuing to insource and outsource in high pressure areas, including Oral Surgery, ENT and Urology. RTT performance was one of the organisation's highest risks at present.
- Emergency Department: 4 hour standard: August was a challenging month and this had continued in September. For RBH 83% of patients were either, admitted, transferred or discharged within the standard. The mean time to be seen at PHFT was 227 minutes. Ambulance conveyances were 2% higher than the same period the previous year. Mr Mould noted that the Medical Care Group had been invited to present performance in the Emergency Department at the Board Development event in November 2020.

Prof Shearman thanked Mr Mould for his comprehensive report and asked how the Trust measured Theatre utilisation. Mr Mould described the national "Adopt and Adapt" scheme, explaining that this sought to return Theatre utilisation to pre-Covid levels. Theatre utilisation was measured differently between Poole and RBH but normally it is measured on how much the session is actually physically used which takes into account anaesthetic start and finish time. The gap in between is then taken off and then when does the next patient arrive in the anaesthetic room. In addition, the Trusts record the number of cases per session and turnaround time. Mr Mould noted that changes in infection prevention and controls guidance for Theatres on 21 September 2020 was also under review. Mr Dave asked what was the role of the patient's GP and the Trust in keeping patients informed and reassured whilst they waited.

Mr Mould explained that both organisations were concentrating on those patients with the highest clinical priority, noting that the Finance and Performance Committee had asked to know how the Trust got the message out to people in the Dorset system to reassure those patients not assessed as a clinical priority and inform them of why there were other patients requiring more urgent treatment. Mr Mould had agreed to propose what message was sent out into the Dorset system. If someone was concerned their condition was deteriorating, then they would be advised to return to their GP and if necessary, the GP should escalate the patient's referral to the hospital.

Dr O'Donnell supported the approach taken by the Trust to prioritise patients on the basis of clinical need. If a patient's symptoms deteriorated and they were concerned they should go back to their GP. Whilst capacity remained limited patients would need to be managed on the basis of clinical need.

Mr Mount reported on work to be undertaken by Mr Mould to assess the level of external capacity available to the Trust and how effectively that external capacity was being used. Mr Mount supported the need to have effective communication to keep stakeholders informed of what was being done to catch up and to inform individual patients of what action they may take should they be concerned or experience worsening symptoms

Mrs Shobbrook presented the report to provide an update on the key performance indicators relating to quality, safety and patient experience. The following key points were highlighted:

- Key items discussed at the Joint Quality Committee on 28 September 2020 included Infection Prevention and Control, the Trust response to the Covid-19 Pandemic and its impact upon clinicians. The committee also discussed the processes in place to prioritise patients that are not in hospital i.e. on the waiting list in the most appropriate way in order to manage patient safety.

- There had been a slight increase in C.Difficile cases. Work was continuing with the Dorset Infection Prevention and Control Team to understand if the slight rise in reported cases of C.Difficile was linked to antibiotic usage in the community.
- The Trust had established a Covid-19 dashboard that is reviewed by the infection control team and performance team every day. The dashboard contained key metrics that allowed the Trust to review the number of Covid-19 cases, the number of staff that may be impacted, any learning that was happening across Dorset and where the Trust sat in relation to the wider Dorset performance.
- Patient falls remained an area of focus for the organisation. Work to reduce the incidence of in-patient falls was ongoing. Identified contributory factors that may account for the rise in falls included delays in offering verbal coaching due to donning Personal Protective Equipment (PPE) and the ability to provide enhanced care (specialling), dehydration, hypoxia and delirium.
- The Committee reviewed a report on Serious Incidents and received assurance from work undertaken by Learning Panels and work with Care Groups in order to ensure consistency in reporting.
- There had been an increase in the number of in-patient moves out of hours, thought to be related to the introduction of more complex pathways with the different Covid and non-Covid areas.
- The Trust continued to receive good feedback from patients despite the fact the Friends and Family Test (FFT) has been paused nationally. The Trust has good oversight of complaints and the Trust response to those complaints.

Mrs Shobbrook reported on action to understand differences in care hours per patient day (CHPPD) between Trust sites. Care hours per patient day were a reflection of nurse staffing on Trust wards. The organisations benchmarked well against the Model Hospital but there was a difference in the way red flags were reported. Both Trusts were working to understand differences in the number of red flags raised at RBCH and PHFT. Mrs Shobbrook assured the Boards there were no reported concerns in relation to unsafe staffing on Trust wards.

Ms Allman provided a workforce update with the key points noted as follows:

- The results of a recent student survey reported very positive feedback in relation to the support they received from the Trust and it was understood many students are planning to join the Trust.
- Statutory and Mandatory training had maintained a reasonable level despite significant disruption due to increased flexibility. The roll out of the virtual learning environment and the ‘green brain’ in January 2021 would help to maintain performance.
- The Trust was very grateful for the commitment and flexibility of staff across the workforce area.
- The staff survey has gone live and the OD and workforce teams were taking every opportunity to promote the survey.
- There are new national metrics that are very similar to those currently reported by the Trust and the Workforce Strategy Committee would undertake to review the workforce metrics that are reported by the Trust.
- Overall we should be very proud of our staff. They have worked very hard and continue to do so. The level of flexibility they have shown was amazing

BOD 152/20 Integrated Quality, Performance and Workforce Report – August 2020

Mr Moss noted the workforce metrics looked very good despite the challenging operating environment. Recruitment was buoyant and vacancies were very low. Mrs Cotgrove suggested future reports should highlight those areas reported as outliers in relation to the workforce metrics and the Workforce Strategy Committee should receive assurance as to the actions and mitigations in place for those areas where action was needed.

Ms Matthews noted the need to ensure staff were supported during what may prove to be a very challenging time ahead. The focus on staff health and wellbeing must be maintained. Mr Mount noted for managers at all levels in the organisation to take time to meet with, coach, mentor and appraise staff in order to maintain staff morale. Ms Allman recognised the importance of ensuring there was an ongoing conversation with staff and that performance was appropriately monitored. The Trust was working to develop a new system of appraisal for non-medical staff and it was fundamental to the values and culture of the organisation.

The report was NOTED.

BOD 153/20 Financial Performance Report: Month 5 (PHFT & RBCH)

Mr Papworth presented the reports to provide an update on the financial performance of both Trusts, with the key points noted as follows:

- The Trust remained in a retrospective true up position such that all Trust costs were reimbursed nationally at the end of the month.
- The Trust remained on the national interim financial arrangements until the end of September 2020
- Both Trusts had reported a YTD financial breakeven position; inclusive of accrued income in relation to the retrospective 'true-up' payment (RBCHFT £3.778m; PHFT £5.424m).
- Capital spend to date totalled £6.709m at RBCHFT (of which £563,000 related to the Trusts COVID-19 response) and £7.683m at PHFT (of which £697,000 directly related to COVID-19). Non COVID-19 capital spend reflected the first year of the agreed joint six-year capital programme.
- Both Trusts had significant cash balances. RBCHFT just over £85m that included payment in advance consistent with current interim arrangements of £23m. It was important to recognise that was a cash balance that had been built up strategically over the last number of years to support the future configuration.
- The PHFT cash balance circa £31m of which £20m reflected the payments in advance.
- Relatively speaking the organisation was in a strong position at this point in the year.
- With regard to the financial position and performance for the back half of the year, previous discussions had noted that the Trust would be moving from a retrospective true up position to a prospective allocation whereby the Trust would receive a fixed allocation at an ICS level and would be expected to live within. This was designed to bring healthcare systems back into financial balance. Allocations were received on 15 September. They are incredibly complex and represent another fairly significant change to the financial architecture within the NHS. The Trust had worked through the detail of the allocation and shared its position with ICS partners both in terms of the Trust's financial and activity plans and what that would mean in terms of performance for Month 7 to 12.
- Organisational plans had been aggregated across the system. The system plan currently showed a very significant financial gap that was currently being worked through.

BOD 153/20 Financial Performance Report: Month 5 (PHFT & RBCH)

Mr Papworth concluded by asking the Board to note four key issues in terms of that financial challenge and what was driving it, as follows:

The first key issue; allocations continued to be based on expenditure reported during months 8, 9 and 10 last year. As the Board was aware the Trust delivered a very significant amount of non-recurrent CIP in months 8, 9 and 10. There was therefore an immediate shortfall against the allocations.

The second key issue; the allocations were based on the national Covid spend during the first quarter of the year. It was then adjusted nationally for items that had a separate funding stream e.g. Nightingale costs but then that was allocated on a fair share basis to individual systems. As such the allocations for specific Covid costs did not align to the local run rate of Covid expenditure.

The third key issue; the allocations assumed that with the exception of staff car parking charges all non-NHS income would be recovered in full, from the 1 October. This was unlikely and one of the more significant areas was around overseas patients where there were far fewer coming into the hospital and private patient income where Theatre capacity was particularly challenged.

The final key issue; the elective incentive scheme, the expectation around phase three recovery was that the Trust would recover within set tolerances broadly Trust activity from last year. If the Trust was not able to recover, then the Trust allocation would be reduced on a marginal rate tariff basis because the national assumption was that the allocations funds the Trust for last year's level of activity.

Mr Papworth noted that these four key issues were driving the significant gap across the ICS and the Trust is currently working through that. Organisations were sharing their detailed phase three recovery plans to allow a prioritisation process to take place across the system and that prioritisation process would be informed by the patient benefits case linked to those investments e.g. how they support the safety, quality and performance of our elective activity going forwards. Mr Papworth reported it was very possible the system would not be able to submit a balanced plan to the regional team by Monday, but the system needed to submit a challenging yet realistic plan that can be delivered, rather than an overly ambitious plan that cannot be achieved.

Mr Papworth outlined the budget setting process advising that Care Groups and Corporate Directorates had been asked to submit a simplified business case for all of the schemes that needed to continue that were currently unbudgeted. This would include current Covid costs that need to continue, additional costs over the winter and also recovering our activity. Broadly, the 100 plus cases had been categorised into four priorities. The first priority concerned keeping the current cohort of patients safe. The second priority was keeping patients safe over an escalated winter period. So ensuring that over the winter period when the hospital started to become busier the Trust was able to maintain rigorous mechanisms to keep patients safe and that would include some expectations around escalation capacity over the winter. The third priority related to recovering elective activity that linked to the phase three recovery plans. The fourth priority relates to those things the Trust would like to do because they add a significant value, but were outside the other three priorities.

Mr Moss thanked Mr Papworth for his very clear analysis of a complex process, noting this had been discussed in detail at the Finance and Performance Committee.

BOD 153/20 Financial Performance Report: Month 5 (PHFT & RBCH)

Mr Green thanked Mr Papworth for his clear explanation. Following on from his earlier question Mr Green reported he still did not understand the principles upon which the allocation would be made and he did not understand what the responsibilities are for the UHD Board, the responsibilities of the other partner boards and the responsibilities of the CCG. Mr Green observed it was important the Board of UHD should really understand this.

Mr Mount indicated his support for points made by Mr Green. A discussion took place regarding the need for clarity of the interface between the UHD Board and the ICS given the degree of dependency that we now have. Mr Moss noted concerns however nothing had changed with regard to the accountability of this Board and how the ICS works.

Mrs Fleming acknowledged this was a hugely important issue and one of the greatest challenges in the NHS at the moment. Mrs Fleming agreed a future topic for a Board Seminar would be to consider what it actually meant to be a high performing organisation within an integrated care system. This was something to be discussed with partners but also as a Board. This was a national issue. In the meantime Mrs Fleming noted the importance of being clear about our responsibilities as a Board of a Foundation Trust and the responsibility to work in partnership with others as part of the Dorset ICS.

It was agreed that time would be scheduled into a future Board Development session to consider the respective accountabilities and responsibilities of the Board and other Dorset System Partners in relation to delivering the system break even position. **Action: DF/CoSec**

The report was NOTED.

BOD 154/20 Mortality Report - Quarter One

Dr Thomas presented a report on Quarter One Mortality statistics for PHFT, with the key points noted as follows:

- The SHMI for PHFT continued to do well and the HSMR remained within statistically normal variation. This report was based on data from CHKS noting that PHFT was moving to adopt the Dr Foster system as used by RBCH.
- When the HSMR is calculated using the Dr Foster method there appeared to be a deterioration in performance. Work was underway to understand why there was this difference and whether it was a statistical issue or if there were other reasons that explained this anomaly. The Trust would undertake deep dive thematic reviews in each of the high-risk diagnostic groups that had been flagged.
- Medical Examiner (ME) reviews continued during Q2. Increased implementation at PHFT with the ME service now reviewing 95% of all in hospital deaths. Work continued to understand the number of reviews that were being undertaken at Directorate level. PHFT was moving to adopt the electronic method for undertaking mortality reviews at RBCH.

Mr Moss thanked Dr Thomas for his report and noted the response given to a question raised by a Trust Governor.

Dr O'Donnell reported on the work underway to gather sufficient information to fully understand the position at PHFT in order to provide a clear explanation and robust assurance to the Board. There had been some good learning from thematic reviews and annual reports in both congestive cardiac failure and in stroke which were two of the diagnoses that would be reviewed as part of the initial Dr Foster report for PHFT.

BOD 154/20 Mortality Report - Quarter One

Dr O'Donnell asked the Board to note items that may impact on all metrics reported over the next six months that would not be a reflection of care. Baseline metrics had gone up a point or two due to the impact of Covid-19. As a result of Covid-19, fewer people had attended hospital and therefore the fall in the denominator population may have an impact on statistical data. This was a national issue due to the Covid-19 pandemic. The introduction of Dr Foster across all sites would enable the Trust to report UHD data, a day one requirement, but it would also allow the Trust to generate site specific reports that may highlight localised hotspots that required further review.

Mrs Tapster assured the Board that the Quality Committee had spent considerable time looking at mortality metrics and this matter would remain as a standing item for future meetings. The next meeting of the Quality Committee would review the analysis of the data and the diagnostic reviews.

The report was NOTED.

BOD 155/20 Phase 3 Recovery Plans

Mr Mould presented an updated position on Phase 3 recovery plans and associated performance trajectories. The key points were noted as follows:

- With regards to Covid-19 the Trust was beginning to see a reduced rate of positive patients but starting to see a small number of admissions and a reduced impact on critical care.
- ED attendances and urgent/emergency admissions increasing
- Patients to attend hospital when really necessary (tele-med/videoconferencing)
- Screening for patients and staff, plus antibody testing remained a challenge
- Recognition of the impact on our staff – wellbeing support continued
- Focus on longer waiting elective patients
- As of today there were three Covid-19 patients in both organisations and nobody in critical care.
- The Covid-19 dashboard was updated three times a day and risks in relation to Covid-19 were reported on a daily basis.
- Norovirus and Influenza and potential Covid-19 surges or spikes locally and nationally will impact on the Trusts winter plans.

Mr Mould set out the three key priorities for 2020/2021; accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity that includes using the independent sector and community hospital theatre capacity. Preparing for winter demand pressures includes retaining processes that worked well during covid.

Winter planning is well underway. There is a single draft plan in place for both trusts that was discussed and the Joint Finance Committee on 28 September. There remained challenges in bed capacity. As reported under item 153/20, work is underway to prioritise schemes for winter. It will be important to focus on the schemes that will have the greatest impact.

Mr Mould reported on work underway, led by Mrs Shobbrook, to understand what support is required to manage ITU capacity during covid. The Trust will retain two covid units on the PHFT and RBH sites in order to maintain the separation of patients .Clinically that is felt to be the safest model going forward. This will mean the loss of circa 30 beds on the PHFT and RBH sites and so the Trust is looking at ways of re-providing those beds over the winter period.

BOD 155/20 Phase 3 Recovery Plans

The Trust has received a considerable amount of national capital funding and work is underway at the 'front door' of PHFT and RBH to provide for separation and the different pathways for patients attending ED. The Trust has received circa £3m capital funding for the critical care units. Enabling work needs to happen to provide facilities in their current location.

Home First represents a different approach to discharge and assess that is based on the principal of supporting people to maximise their independence and remain in their own home. Home First moves assessment out of hospital and into people's homes or their usual place of residence. The discharge to assess pathways under Home First are prescriptive and consist of Pathway Zero, One, Two and Three. The most important pathway for the Trust is Pathway One where patients are discharged when they're medically ready to leave or they no longer meet the criteria to reside. As of today as an organisation, there are 115 patients who are medically ready to leave or don't meet the criteria to reside. The Trust is discussing this position with the system in order to identify a way forward.

The Trust has been meeting monthly to discuss preparation for the EU transition. I preparation for transition the Trust will move to weekly meetings and when necessary, daily meetings. The Trust has plans in place to mitigate any risks I relation to the supply and cost of food. Nationally there is a six weeks of stock of supply of medical devices and consumables. The Trust is working to understand the impact of Covid-19 on stocks of medical devices and consumables.

The South West is performing well as a region, There are two areas of concern, the number of 12-hour trolley waits in emergency departments across the South West and RTT, in particular the number of over 52-week waits.

Against the Trust's 7 priority specialty level 52-week recovery programmes, the areas of challenge in delivering the recovery trajectories are Ophthalmology, surgical procedures and access to theatres. Even with all the action being taken it is expected the Trust will end the year with over 3000 people as over 52-week waiters.

As reported earlier Mr Mount has asked the Trust to review its use of the Independent Sector. Existing contracts have been extended until the end of November and the Trust is working hard to use available capacity.

Mr Mount noted the need to update the risk register to reflect risks identified in relation to the recovery plans.

Prof Shearman asked to know what Covid-19 testing policy the Trust had for asymptomatic staff and patients coming in for elective surgery. Dr Thomas confirmed NICE guidance for testing was 72 hours beforehand with self-isolation so that by the time the patient attended for admission the result was known and the patient had self-isolated.

Dr Thomas noted there were two issues: firstly, testing had had pressures over the last few weeks and the timescale for those results to come back had got close to the 72 hours. The other issue was that in some areas patients were not always self-isolating as they should before they attended their appointment.

Mr Dave asked to know what conditions were reported in those 3,000 over 52-week waiters. Mr Mould explained that at the moment there were 100 people on the orthopaedic list waiting over 52 weeks. At the end of the year there would be 1,000 people waiting over 52 weeks. A significant number of orthopaedic patients were hip and knee replacements.

BOD 155/20 Phase 3 Recovery Plans

Mr Mould noted that the Trust would use every opportunity to increase capacity and turn things around and the better the Trust got at managing the pathway the better the Trust could utilise available capacity across the whole system.

Mrs Shobbrook noted that national policy was changing rapidly and the task for the Trust was to translate changes in policy into practice in order to have a positive impact for patients. The Test and Trace App had been launched nationally and staff had been encouraged to download the app but be mindful of its use when working in hospital. The CQC had been assured by the work at PHFT and RBCH to maintain levels of infection prevention and control and this was reported to the Joint Quality Committee.

Mrs Tapster noted the Home First initiative was discussed at a recent meeting of the Joint Finance Committee. Given there were 115 patients who were medically ready to leave or did not meet the criteria to reside, Mrs Tapster asked to know what would be different this year. Mr Mould explained that Home First was a national requirement that should be implemented regionally, locally and within organisations and the Dorset system was accountable for its implementation. Dorset Healthcare was a key player, and they were leading Home First. The system would not operate and function without the implementation of Home First.

Mr Mount noted his own experience of hip and knee replacements served to highlight the need for early intervention of physiotherapy before operations. With the number of people on the orthopaedic waiting list was there more opportunity for involving physiotherapy to assist those patients on the waiting list. Mrs Shobbrook confirmed such arrangements are being out in place through the ICS.

The report was NOTED.

Mr Jablonowski left the meeting.

BOD 156/20 Charitable Funds Expenditure over £25k

Mr Papworth presented the report to seek support and approval of the award decisions made by the Joint Charitable Funds Committee on 24 September 2020 as follows:

- Enhanced Staff Wellbeing Support: £92,763.50 against allocation of funds already received (note that this is part of a joint bid with RBCH charitable fund).
- A Local Recognition Fund: £44,440 against allocation of funds already received (note that this is part of a joint bid with RBCH charitable fund).
- Health and Wellbeing Support for Underrepresented Groups: £50,000 against allocation of funds already received (note that this is part of a joint bid with RBCH charitable fund).

The Boards of PHFT and RBCHFT APPROVED the charitable award decisions.

BOD 157/20 Annual Complaints Report 2019/20 - RBCH

Mrs Shobbrook presented the Annual Complaints Report 2019/20 for RBCH, which had been presented to the Joint Quality Committee and Healthcare Assurance Committee. The key points were noted as follows:

- This report served to demonstrate responsive care for patients.
- There had been a slight decrease in the number referred to the PHSO and a decrease in the number upheld, demonstrating a positive process for investigating and responding to complaints.
- Following approval, the Annual Complaints Report 2019/2020 would be published on the Trust website.

Prof Shearman noted response times in 2019 were changed and asked to know what the response time had been over the last year. Mrs Shobbrook reported that response times for PHFT and RBCH were aligned earlier in the year. Mrs Shobbrook noted the response time had not improved as much as the Trust had hoped, although the number of complaints coming back for further questions and responses had reduced. Some complaints may be more complex and include an incident that required investigation.

The RBCH Annual Complaints Report 2019/20 would be published on the Trust's website.

Action: PSh

The Boards of PHFT and RBCHFT APPROVED the RBCH Annual Complaints Report 2019/20

BOD 158/20 Annual Safeguarding Report – 2019/20 RBCH and PHFT

Mrs. Shobbrook presented the Annual Safeguarding Report, 2019/20 for RBCH and PHFT. The key points were noted as follows:

- These are statutory reports that have been reviewed and discussed at the Joint Quality Committee on 28 September 2020.
- Both reports provided evidence that PHFT and RBCH meet their statutory requirements for NHS organisations to discharge their safeguarding children and adults' obligations, under the requirements of Section 11 of The Children Act 2004 and The Care Act 2014.
- Safeguarding training had been arranged for the new UHD Board in October.
- For RBCH there was an increase in the number of adult safeguarding concerns raised during 2019. Each concern was reviewed by the multi-professional team in the light of Section 42 criteria. The numbers of concerns meeting Section 42 criteria remained the same. An increase in the number of concerns referred to the service indicate an understanding within the organisation of the need to escalate concerns when they are identified.
- Themes identified for both organisations included the need to ensure we have the right processes in place for safe discharge.
- The number of patients with learning disabilities had increased and that was being monitored very closely with the support of a learning disabilities nurse.
- There had been an increase in the number of patients requiring Deprivation of Liberties Safeguards. Changes in the legal framework are expected in 2022.
- Both reports were approved with the recommendation they would be taken to today's meeting with a recommendation for approval and, subject to Board approval, published on the Trusts' websites.

BOD 158/20 Annual Safeguarding Report – 2019/20 RBCH and PHFT

The RBCH and PHFT Annual Safeguarding Reports 2019/20 would be published on the Trusts' websites. **Action: PSh**

The PHFT and RBCH Annual Safeguarding Reports 2019/2020 were APPROVED.

BOD 159/20 Workforce and Organisational Development Committee Annual Report (PHFT)

Mrs Stone introduced the PHFT Workforce and Organisational Development Committee Annual Report 2019/2020. The key points were noted as follows;

- This report was presented to the Joint Workforce Committees earlier in the month.
- The report confirmed the terms of reference for the Poole Workforce and Organisational Development Committee were met. The report included detail of the work of the Committee over the previous financial year and the deep dives that were undertaken.

Mr Ziebland, chair of the Poole Workforce and Organisational Development Committee expressed his thanks and best wishes to all those who supported the work of the Committee and the support received from Non-Executive and Executive colleagues.

The Boards of PHFT and RBCHFT NOTED the PHFT Workforce and Organisational Development Committee Annual Report 2019/2020.

BOD 160/20 Questions from the Council of Governors and the Public arising from the agenda

Mr Moss advised questions from the Council of Governors and members of the public were submitted ahead of the meeting. Mr Moss read out the questions on behalf of the Council of Governors as follows:

- Mr Chaffey asked about the future plans for the current St. Mary's Maternity Hospital at Poole and whether it was to be used for another purpose when maternity services moved to RBH. Is it to be demolished and if so, what will the site be used for and what is the approximate value of the site.

Mr Renaut advised that the Maternity Unit would not be moving to the Bournemouth site until 2025. Thereafter, the Trust would look at the best use of the site, noting that key worker housing would be a good use. The building was old, and it was therefore unlikely it could be utilised for a health use.

- Dr McLeod noted he had not seen any convincing evidence for how the Trust will improve waiting times for debilitating and painful conditions. Are the issues financial? Are they personal related? Clearly with Covid-19 we have seen longer delays in accessing diagnostics and treatment. Is the Trust making use of recently retired consultant staff?

Dr O'Donnell advised that the answer was multifactorial. There wasn't a financial impact at the moment as the Trust receives funding for Covid-19 costs. The big issue was that our capacity was significantly limited by the infection prevention measures and social distancing that had to be in put place. That meant the efficiency of lists was not what it was and there are lots of different answers to that. Some was about increasing the amount of estates or facilities we have to put procedures through.

BOD 160/20 Questions from the Council of Governors and the Public arising from the agenda

Dr O'Donnell noted the Trust was very aware that we don't exhaust our staff even more then they are feeling. Where there are opportunities to insource and outsource work, we are taking those opportunities. There isn't a single answer that gets the Trust back to where we would like to be. It's going to be about chipping away at all of those different aspects, improving efficiency as much as we can, looking at opportunities to insource and outsource work and broadening our workforce. Where we have opportunities to use other workforce then absolutely, we are open to that.

Mrs Cleary observed that she welcomed the Board's noting of the contribution of the staff, as a Staff Governor and in her role as an OD practitioner looked forward to seeing the charitable funds being put into action to support staff. Mrs Cleary noted that as a member of staff of this organisation she felt involved, aware of what is happening and know to whom she could direct questions and would expect to receive the information.

Mr Bufton advised that with regard to Mr Chaffey's question, the matter was raised two months ago at the Finance and Investment Committee meeting. He and Mrs Houghton had a conference call with Mr Papworth and Mr Renault. Mr Renault had produced a draft paper entitled 'Approach to Land Use' which dealt with the approach to disposal of any surplus land within the Trust Estate.

Mr Triplow as Lead Governor for RBCH, noted from a Governor perspective this was a good, yet sad day because it is the last time, we will actually exist as a group and noted he had been honoured to participate in the interviews for the CEO, the Chair, all Bournemouth Non-Executive Directors, Non-Executive Directors for the new Trust and part of many of the panels for the directors. Mr Triplow observed that in his opinion the appointments were right and a superb base for the new Trust. On behalf of the RBCH Council of Governors, Mr Triplow noted his best wishes to Alex and Ian and the role the Chairman had played in supporting being on all relevant Trust committees, the lead governor being given time on the board agenda to report back on our activities and conclusions and every other meeting. The Governors wish Debbie, David, Alyson, the two Peters, Richard, Paul, Mark, Karen and all the Non-Executives all the very best.

Mr Moss thanked Mr Triplow for his kind words, noting his gratitude for the contributions made and wished those standing for election all the best.

BOD 161/20 Any Other Business

Mr Moss paid tribute to the Directors that were standing down today. We want to place on record our appreciation for those Directors who are standing down. David Walden, Dr Calum McArthur, Nick Ziebland, Alex Jablonowski, Patricia Reid and Jacqueline Cotgrove together with Dr Matt Thomas, Deborah Matthews and Donna Parker who were staying with us but in different capacities for the future. Dr Matt Thomas as Deputy Chief Medical Officer, Deborah Matthews as Director of Organisational Development and Donna Parker as Deputy Chief Operating Officer. We are very grateful to you too. Finally, Mr Moss noted that importantly two of our key secretariat members are moving on. Catherine Horsley is moving on to work for Dorset Council. Anneliese Harrison is moving across to the Commercial Services Team. Mr Moss extended his best wishes on behalf of the Boards.

BOD 162/20 Key points of communication to staff

Mr Moss noted the following points for communication to staff:-

1. Covid Recovery and Winter Planning.
2. Home First
3. The EU transition
4. Charitable Fund Investments to improve staff facilities and wellbeing.
5. The launch of University Hospitals Dorset NHS FT.
6. We at the end of an era. Both Boards can be very proud of what's been achieved in the 29 years of existence of the two Trusts. A significant period in the history of the local NHS. Tomorrow sees the launch of University Hospitals Dorset NHS FT. A number of events have been planned throughout the day.

BOD 163/20 Date and Time of the Next Public Meeting

The first public Board of Directors meetings of University Hospitals Dorset NHS Foundation Trust will be on Wednesday, 25 November 2020 at 13:15 via Microsoft Teams

Members of the public were asked to withdraw from the meeting.

Agreed as a correct record of the meeting:

*Chairman*_____ *Date* _____

University Hospitals Dorset
NHS Foundation Trust

MATTERS ARISING: ACTION TRACKER NOVEMBER 2020

Meeting Date	Minute No.	Matter Arising / Action	Trust / Lead	Due Date	Update
30/09/2020	BoD 157/20	The RBCH Annual Complaints Report 2019/20 would be published on the Trust's website.	PSh	October 2020	Report sent to Communication Department for uploading on to the website: 9/10/2020
30/09/2020	BoD 158/20	The RBCH and PHFT Annual Safeguarding Reports 2019/20 would be published on the Trust's website.	PSh	October 2020	Report sent to Communication Department for uploading on to the website: 09/10/2020
30/09/2020	BoD 153/20	The Emergency Department Teams would be invited to a future Board Seminar to provide an outline of their plans and for the Board to understand what the Emergency Department Teams require of the Board to continue to improve the experience of patients in the Emergency Department.	Carrie Stone	November 2020	On Board Development Programme event: 25 November 2020

Key:	Outstanding	In Progress	Complete	Future Action

University Hospitals Dorset
NHS Foundation Trust

FUTURE ACTIONS

Meeting Date	Minute No.	Matter Arising / Action	Trust / Lead	Due Date	Update
30/09/2020	153/20	It was agreed that time would be scheduled into a future Board Development session to consider the respective accountabilities and responsibilities of the Board and other Dorset System partners in relation to delivering the system break even position.	DF/CoSec	Future action	A presentation on the Dorset ICS was scheduled for the October 2020 Board Development event.
30/09/2020	Part 2	The Trust's Sustainability Strategy would be presented to the Board of Directors in January 2021	RR	January 2021	Noted for January 2021 agenda

Key:	Outstanding	In Progress	Complete	Future Action

BOARD OF DIRECTORS MEETING
25 November 2020

CHIEF EXECUTIVE REPORT

1. Update on Covid-19 within our hospitals

Increasing pressures

Members will be aware that the past few months have been incredibly busy and pressurised within the Trust, as all teams and departments have been focusing on developing the new pathways for Covid-19 patients, treating the increasing numbers of Covid-19 patients being admitted to our wards, and/or working to reduce the waiting times that have increased as a consequence of the pandemic. I should like to take this opportunity to thank staff for their commitment, professionalism, hard work and tenacity during these unprecedented times.

Since the government's announcement on 31 October of the national lockdown measures, the NHS has now returned to the highest level of emergency preparedness, Incident Level 4. This decision was taken by the national team following the increased demand on our hospitals from rapidly rising rates of Covid-19 infections in many parts of the country. Despite a national lockdown having been activated from 4 November, at the time of writing, there is not yet any indication that the pressure is reducing, as the case rate in England continues to rise.

Whilst the South West region has generally been less affected than other parts of the country in terms of the rate of infection and the number of hospital admissions relating to Covid-19, there has been much concern over the past few weeks over the rapid pace at which this has been changing. At the time of writing, we are seeing the same trends as other parts of the country, with the number of new infections in the South West growing by 4% to 7% every day. At the time of writing, the R rate in the South West is between 1.2% and 1.4%.

At the time of writing, we currently have 102 patients admitted at UHD whom have tested positive for Covid-19. Of those, 9 patients are currently on ITU and receiving specialist care.

Whilst the current situation is extremely worrying, it is important to note that the NHS as a whole (including of course our own organisation) has learned so much from the first wave. This will make a very significant difference to the way in which we will manage now that we are dealing with a second wave, and we expect better outcomes for our patients. For example – we have new life saving treatments such as dexamethasone (trialled and tested in the NHS), and we better understand the type of oxygen therapies patients that patients need. We have developed a number of new pathways and modified a number of our wards and departments so as to enable us to separate Covid-19 patients from other patients who are admitted to our hospitals or are attending for treatment. We also have a much better understanding of the best ways in which to care for Covid-19 patients in order to aid their recovery.

Against this backdrop, it is important to note that the fourteen-day survival rate for patients in intensive care (national rate) has improved from 72% to 85% since the pandemic began. With regards to critical care capacity - an escalation plan has been agreed across our two acute hospital sites (RBH and Poole), and if necessary, additional support can be accessed from the wider Wessex Critical Care Network.

As a consequence of all the above, our hospitals are much better placed to respond to the second wave than we were at the time of the first surge.

Covid-19 Outbreaks

Members will be aware that in recent weeks, there has been an increased focus on the number of Covid-19 outbreaks across the NHS. The definition of an outbreak in this context is where two or more patients and/or staff have developed an infection.

The national position is now published weekly, as the number of cases tested at >=8 days from admission to hospital as a percentage of new inpatient Covid-19 cases. Both Poole Hospital and the Royal Bournemouth Hospital (RBH) have had outbreaks of Covid-19 in recent weeks, with the number of patients at Poole Hospital being significantly higher than at RBH. As a consequence, for the month of October, UHD was cited in the media as having one of the highest levels of probable hospital acquired Covid-19 in the country.

It is important to note that over the same period, we were seeing very high levels of Covid-19 in the community. We have therefore seen an increase in the number of staff and patients who are positive for coronavirus without displaying symptoms, but who are still able to pass it on to others. As you would expect, decisive action has been taken to address this situation within our hospitals, in line with our infection prevention and control policy. This includes the restriction of visiting, the cohorting of patients, and the introduction of asymptomatic staff testing within the outbreak areas. We are also continuing to reinforce and strengthen all of our infection, prevention and control processes. These are of course in addition to the national lock-down which has now been introduced, which is expected to play an important part in bringing down infection rates.

The Trust has been working very closely with Public Health England, Dorset CCG and the CQC to ensure that all appropriate action is taken within our hospitals, in line with best practice. As such, we are confident that the current situation is improving. Nevertheless, it is important to note that if such high levels of Covid-19 are still prevalent, sporadic outbreaks are likely to continue going through the winter period.

Impact on Winter Planning: system surge and escalation

As always at this time of year, the focus of the Trust is on ensuring that we have sufficient capacity in order to meet demand during the busy winter period. Of course, managing the winter in the context of the pandemic, and at a time when we are experiencing a second wave makes this even more challenging. Our clinicians and senior leaders across the organisation have therefore been working very hard to identify all possible ways of creating additional bed capacity and maintaining hospital activity throughout this busy period. The situation is made even more challenging in light of the reduced bed capacity within both acute hospitals, in order to maintain safe space/social distancing on our wards.

At the same time, the Trust is also doing everything possible to preserve outpatient and elective capacity. This includes working with the Independent Sector and maximising the use of telemedicine/ remote consultations, so that patients only attend hospital when absolutely necessary. It is recognised that there are now large numbers of patients waiting much longer than normal for treatment, but everything possible is being done to address the situation, against the backdrop of the Covid-19 pandemic. Again, I should like to take this opportunity to thank our staff for all their hard work as we have been working to treat as many patients as possible, under these very difficult circumstances. It is important to note that to date, UHD (and indeed, the wider Dorset system) has performed well against a number of the measures being used to measure recovery, in particular, with regards to the diagnostics standard (DM01). Our latest return showed a significant improvement from 83.1% in September to 90.2% in October.

One of the top priorities for the organisation is to ensure that no patient stays in hospital longer than is absolutely necessary, and as such, we are working with our partners in the Dorset system to do everything possible to ensure the safe and timely discharge of patients. Once again, this is now more complex than ever before, given the challenges associated with the shortage of nursing home/care home places and packages of care in the community, as care providers seek to manage the challenges of Covid-19. We are continuing to work with our partners to create additional capacity in the community, so that we might safely discharge our patients and maintain flow within our hospitals, but at the time of writing, there are116 patients still on our wards who are medically fit for discharge.

Finally, it is important to note that as part of the NHS emergency response, the Dorset System Silver meetings remain in place, which enables an oversight of the position across all health and social care partners, and the opportunity for mutual aid and support.

Supporting our Workforce

With all the challenges associated with Covid-19 and the winter, it is clear that our staff are once again working under significant pressure - at a time when many are still getting over the challenge of the first wave of the pandemic. Staff risk assessments remain under regular review, particularly for our vulnerable and higher risk colleagues, and there are now fewer staff shielding, in line with new national guidance. Unfortunately, the sickness rate has increased significantly over the past few weeks, with more staff away from work or isolating due to Covid-19.

The Trust is very much sighted on the emotional and physical burden that these operational pressures and workforce gaps mean for our staff. It has become very clear that there is an on-going need for support for our staff, and as such, we have maintained the enhanced wellbeing service that was mobilised at the start of the pandemic. This includes the re-provision of "safe spaces" and access to rest areas, which is so important for staff during these stressful times. Space has been designated on all our sites for this purpose, but further work is needed to ensure that all individuals are able to access such a facility during their break times and/or at period of particular pressure.

Update on Testing

Whilst the Dorset system has not been well served with access to rapid turnaround Covid-19 testing, we have continued to work to increase capacity and this is set to improve further over the next few weeks. We are increasing the numbers of staff to run the service, which will allow us to improve access to rapid testing over the 24/7 period via two platforms - GeneXpert and Samba 2. The increase in workforce capacity will also improve our ability to carry out more of the 4 hour turnaround tests. In addition, we shall soon be installing a new high-throughput platform which will be active from mid-December once staff are appropriately trained. This will give us access to approximately 120,000 tests per day, which will reduce our reliance on external laboratories.

All trusts have now been notified of the Standard Operating Procedure for the NHS rollout of lateral flow devices that will allow for asymptomatic staff testing. 34 trusts are currently piloting this new process, with all Trusts (including UHD) expected to started providing asymptomatic testing for all front facing staff by mid-November.

The precise arrangements for implementing this new initiative are currently being worked through within the Trust, in accordance with national guidance. However, this is clearly a very important development, which will significantly assist us in reducing spread within our hospitals.

Update on the Vaccine

As members will be aware, very significant advances have been made in recent weeks in the development of a vaccine against Covid-19. Pfizer UK and BioNTech have been focussing on technology called an mRNA vaccine, with early data showing that it can protect more than 90% of people from developing Covid-19 symptoms. In line with national guidance, we are now working with colleagues across the Dorset system on a mass vaccination programme for local people.

This is an extremely large and complex programme, and given the large numbers, we shall need to utilise every option open to us, building on the tried-and-tested rollout plans for influenza vaccine, which is deployed every autumn This will include utilising the existing expertise and infrastructure of our local Primary Care Networks (PCNs) and community pharmacists, as well as all local NHS trusts.

The programme will involve providing the vaccine for a number of different cohorts over time, starting with care home residents and staff, health and social care staff, and those over 85. It is hoped that this programme will be able to commence - initially with limited numbers - at the beginning of December.

Due to the complexities of the storage requirements for the vaccine (liquid nitrogen), Dorset County Hospital NHS Foundation Trust (DCH) will serve as the hub. There are already active workstreams in place for workforce, data and IT, communications and primary care, as well as close links with the social care cell, which includes representatives from care/nursing home providers, our two local authorities and community care services.

This is a hugely encouraging and exciting development, and all Dorset partners will be playing a part in this programme. Further information will be shared as this becomes available.

Maternity Services under Covid-19

One of the areas that has been of particular concern across the country during the Covid-19 pandemic has been the provision of maternity services. Our maternity teams are very aware of the additional stress for families that the Covid-19 restrictions can create and have been working hard to address them. The Trust has been absolutely committed to following national guidance and protecting pregnant women and their families, whilst at the same time protecting our workforce.

Every effort is being made to maintain the best possible care and outcomes, recognising that our main maternity unit at Poole is an older building, built in the 1960's, with our staff having to work within a more constricted environment than most other parts of the country. Of course, one of the main benefits of the Dorset reconfiguration of services is that we shall have a brand new maternity unit on the RBH site, built to modern standards and building specifications, but until this facility becomes available, the existing building continues to impose some constraints.

Within UHD, we have completed detailed risk assessments with our infection control teams against all of the national requirements, recognising how very important it is within this setting to maintain safe social distancing. The current position is as follows:-

- we have reintroduced partners at the 20 week scan, which is where the baby is checked for abnormalities and any complications. We recognise that this will not meet all women's requests and are doing everything possible to continue to support women during this difficult time;

- we do not prohibit birth partners from being at the birth, recognising that this is a vitally important time for women. If a woman arrives in spontaneous labour, her partner will come in with her to the maternity unit.

Our midwifery team also recognises how very important it is for women to have familiar support with them at this special time, as well as the importance of family bonding. As such, everything possible is being done to support individuals and their families, whilst at the same time, ensuring that all the necessary precautions are taken to maintain safety.

Unfortunately, whilst doing all we can to support women and their families, we still have to restrict access to these services. Not to do so would mean that the provision of our maternity services would be at significant risk, and we might not able to keep our units open and safely staffed for the remainder of the pandemic. We will of course continue to keep the situation under review.

2. Developing our New Organisation

Values

Members will be aware that over the past few months, our hugely committed Culture Champions have been conducting a listening exercise to ascertain the views of staff regarding the values for our new organisation. As well as holding a large number of focus groups and discussions, over 2000 staff took part in a survey, along with 500 members of the public. The results of this work were then reviewed and themed by our Culture Champions, and presented as recommendations to the Trust Board in October.

I am now delighted to confirm that after months of extensive work, our new UHD values have been formally agreed, as follows:-

- We are caring
- We are one team
- We listen to understand
- We are open and honest
- We are always improving
- We are inclusive

This work is extremely important in that these values will be used as part of our recruitment and appraisal processes, and will shape the way in which we behave towards our patients and each other. As such, this agreement marks a vital stage in the development of our organisation, and will shape the culture within UHD for many years to come.

I should like to take this opportunity to thank Deb Matthews our Director of Organisational Development for overseeing this work and ensuring that it has been carried out so extensively, and to such a high standard. I should also like to thank all those who took part, and of course, our Culture Champions, who gave up so much time in order to complete this important piece of work.

Transformation

Our new Strategy and Transformation team has come together seamlessly and colleagues have defined a clear set of priorities, as well as aiming to restructure work by March 2021. The priorities can be split into the following key areas:

- final integration activities relating to the merger transaction
- ensuring the integration of corporate and clinical services, and delivery of the Post-Transaction Implementation Plans (PTIP)
- taking the action required to secure the capital needed to progress with our building programme
- taking forwards the Theatres development work at Poole Hospital
- taking forwards the office strategy and creating a flexible working environment
- undertaking the enabling work for the new models of care - such as communications, planning permissions and travel planning
- undertaking the transformation work required to support the operational work associated with Covid-19
- setting up our new planning and governance arrangements
- engaging on the new team “discovery and design” process

The new transformation governance arrangements have now been established, with the first meetings held in October and November. The former Merger Steering Group has been re-purposed into the Integration Steering Group, to ensure that the plans that were in place prior to merger are delivered post-merger. This group met in October and will meet for one final time in December. These activities will then be deemed “business as usual” and will be allocated to the staff appointed to new roles within UHD.

The on-going integration activity will continue to be overseen by the Transformation and Improvement Group (TIG), chaired by Dr Isabel Smith, Medical Director for Transformation. This will be the forum to which all other Transformation Groups report. The TIG will report to the Trust Management Group, which includes all the Chief Officers for the organisation and the Care Group leads. A Benefits Realisation Group is also being established to ensure that we deliver the benefits that have been planned as part of the merger transaction.

Given the importance of this work, a formal sub-committee of the Board has been established to oversee the Trust transformation strategy - ensuring that any risks are appropriately managed and that the benefits of our merger are fully realised. The new Transformation Committee will be

chaired by one of our Non-Executive Directors Pankaj Davé, who has significant experience of transformation activity outside the NHS.

Governor elections
The nominations for the election of public and staff governors for the Council of Governors for our new organisations opened on 16 October 2020 and closed on 2 November 2020. The ballot commenced on 20 November 2020, with the declaration of results expected on 11 December 2020. The number of nominations that we received, both in the public and staff constituencies, means that all seats (with the exception of the Medical Staff constituency) will be contested. In the intervening time our key stakeholders; Bournemouth University, Dorset Council, BCP Council and NHS Dorset CCG have all nominated one individual each to join the Council of Governors as appointed governors with a three year term. A nomination is currently being sought from the Trust's Volunteer Group.

Shaping future merger guidance
Members will be interested to note that as part of our on-going approach to learning and sharing with others, we have had discussions with senior representatives of NHS Improvement to discuss our experiences of the recent transaction. NHS Improvement is currently revising its merger transaction guidance, and they expect to take account of our experiences as well as that of other recently merged organisations in developing this important document.

One of the great strengths underpinning our merger application was that we had a really strong, clinically-led patient benefit case, right from the start of the merger process. Our system partners were also very engaged, and very much supported our application to merge. Finally, it is important to note that we benefitted very much by learning from other sites and those who had recently gone through a merger process. It is hoped that this feedback will be incorporated into any future merger transaction guidance.

3. Capital Programme

Our extensive capital programme continues, utilising all the Covid-19 allocations and the Transformation capital to ensure the delivery of a large number of projects - not only throughout the remainder of 2020/21, but indeed, over the next 5-10 years. We have an excellent capital team taking forward these changes, doing everything possible to ensure that our organisation harnesses maximum value from the money that has been entrusted to us.

Members will be aware that there are a number of key milestones in November and December as we will be receiving the Guaranteed Maximum Price for:

- Theatres Complex on the Poole site and;
- Maternity, Childrens, Emergency and Critical Care Centre on the Bournemouth site.

The Poole Hospital programme has commenced early and a new tunnel connecting the Eddie Hawker Wing to the main hospital has been established. The tunnel is for use by patients and staff and opened at the beginning of November. The construction site will be formally handed to our construction partners (IHP) at the end of this month in order to commence the demolition work.

The Trust is working very closely with BCP Council to achieve full planning on the Royal Bournemouth Hospital site and agree the reserved matters that will allow early enabling work to commence in January or February 2021.

Representatives of the Trust had been due to attend the Joint Investment Committee (that is, a combined meeting involving representatives of the Department of Health and Social Care and NHS England/Improvement) on 13 November 2020 to agree the Outline Business Case for the creation of the major emergency and the major planned care sites. Unfortunately, this meeting has now been postponed until December.

Finally, members will wish to note that the team is now re-commencing the clinical design work aimed at creating additional beds across our sites. This programme of work will review and finalise the plans for the creation of the agreed number of beds on both sites, in order to establish the Emergency and Planned Care hospitals. These changes will be delivered through the "New Hospital Programme" funding that has been allocated to UHD.

4. EU Transition

Members will be aware that the UK exited the EU on 31 January 2020 and is currently in a transition period that will ends on 31 December 2020. Professor Keith Willett (Strategic Incident Director for Covid-19 and Strategic Incident Director for EU Exit, NHSE & I) wrote to NHS stakeholders on 4 November with regards to the next steps, confirming how Trusts are expected to prepare for the end of this transition period. Whatever the outcome of negotiations led by the government, there will be changes that affect the health and care sector.

Within UHD, our EU Exit Senior Responsible Officer (SRO) is Mark Mould, Chief Operating Officer, who is working with colleagues to ensure that all necessary action is taken, in line with national guidance. The Dorset Local Resilience Forum (LRF), of which UHD is a member, continues with its transition planning and colleagues within UHD meet on a regular basis to monitor risks and ensure that all necessary mitigation is put into place.

5. Good News

Poole Hospital site
Visitors to Poole Hospital may have noticed an increase in the construction activity as we begin to develop our new operating theatre complex. November marked the start of these major works, which form part of the £250m transformation of our hospitals. The scheme will see the construction of a new state-of-the-art theatre complex with 10 new theatres and expanded day case provision, replacing the original theatres built in the 1960s. Enabling works and the demolition of some temporary buildings are paving the way for the work to start in earnest, with the programme due to be completed in early 2023.

Elsewhere, the Dolphin restaurant has reopened after a £250,000 refurbishment. I would like to take this opportunity to express a big thank to Poole Hospital Charity, their donors and supporters, for making these improvements possible.

The Royal Bournemouth Hospital site
Members of the public and staff have been volunteering to help in the efforts to find a safe and effective vaccine for Covid-19. There has been some exciting developments in the search for such a vaccine in the newly opened research hub, and it is really encouraging to see that members of the public in some of the higher risk groups, for example those with stable pre-existing health conditions, those over 65-years-old or from Black or Asian ethnic backgrounds, have been recruited to the vaccine trial study. The trial will involve over 500 people in total, so thanks to all who have volunteered.

General
Across Dorset more than 50,000 video consultations have taken place with consultants, doctors and specialist nurses. Video consultations are a new way that our clinicians can see patients in these challenging times. The advantages are clear, in that they support our efforts to socially distance within our hospitals while removing potential issues such as parking, travel and childcare. I am delighted that our clinicians have embraced this technology and approximately 95% of patients said that they were likely to recommend video consultations to a friend or family member.

Mrs Debbie Fleming
Chief Executive

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: Wednesday 25th November

Agenda item: 7.1

Subject:	University Hospitals Dorset NHS Foundation Trust - Recovering Our Activity and Covid Update Briefing Paper

Prepared by:	Executive Directors, Donna Parker
Presented by:	Executive Directors for specific service areas

Purpose of paper:	To update the Board of Directors and relevant Committee members on the Trust's current position relating to: • Operational activity and management in the context of Covid 2nd Wave and EU Exit transition • Elective activity recovery • Staff wellbeing and flu vaccination Appendix A (to follow) – *Full slideset (updated to current incident levels/organisational sitrep) will be circulated in advance and presented to the Board of Directors meeting.*
Background:	The Trust is doing well in balancing the response to Covid-19, non covid activity and safely maintaining a proportion of elective activity. This is in the context of increasing Covid incidence across Dorset and our hospitals. Our principles remain that of good planning together with an escalation approach that allow us to adjust flexibly to triggers and respond to the range of demands. This, whilst doing all that we can to support the health and wellbeing of our staff. The increasing complexity of the demands on all of our services and in the context of a reduced workforce due to Covid, does mean that we are facing increasing challenges in balancing our capacity and covid/non covid pathways.
Key points for Board members:	**Areas of Board Focus** 1. Increasing incidence of Covid across Dorset and within UHD in terms of patients and staff. 2. Tactical and Strategic incident management approach in place so support ongoing review of 2nd Wave, winter, EU Exit and other operational plans as well as trigger based escalation.

	3. Maintaining robust infection control protocols and management remains critical. Increasing incidence, distancing as well as repeat swabbing requirements (e.g. 5 day) means significant bed closures and lack of flexibility created by ringfencing Covid / non Covid pathways and wards. 4. Wellbeing support to our staff remains a priority with previous 1st wave actions being stepped back up to support during 2nd wave. 5. Board ambition to achieve 100% staff vaccination remains. 6. EU Exit transition remains a risk, noting local, regional and national framework for planning and response management is in place. 7. Phase 3 elective activity recovery is making good progress and we are seeing an improvement in RTT and diagnostic overall performance. 52 week waits remain a challenge though we are 'bending the curve'. 8. Without a reduction in covid incidence, a reduction in urgent care demand and/or delivery of an improvement trajectory for the discharge of medically optimised patients and/or reduction in staff absence due to Covid, risk remains to elective care activity. **High Level Actions include:** • Internal Tactical and Strategic management approach (including operational 'cells') in place, linking in to Dorset exec level Silver • Winter plan / 2nd wave plan (incl beds) is in place (presented separately to Board) • Infection Prevention and Control cell in place with daily review meetings and pathway risk assessment process, reporting to Director of Infection Prevention and Control. Includes all aspects including PPE, estate, cleaning, staff training, cohorting, visitor guidance, staff movement etc. • Covid / Non Covid pathways established and configurations and pathways, including distancing, remain under close review • Full communications plan established and including significant focus on IPC practices • Staff wellbeing plans mobilised including safe spaces and food/hydration visits • System-wide escalation and oversight of additional care home/community capacity is underway to support step change reduction in Medically Optimised patients in acutes awaiting discharge • Continuation of phase 3 recovery activity and OPAD programme, though this remains closely monitored through Tactical and Strategic. Regulators are sighted on our plans and position and regularly updated.

Options and decisions required:	No decision required – for information and discussion
Recommendations:	**Members are asked to:** Note the areas of the Board focus for discussion
Next steps:	Work will continue in addressing the actions raised.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Continually improve the **quality of care** so that services are safe, compassionate, timely and responsive – achieving consistently good outcomes and an excellent patient experience To be **a great place to work**, by creating a positive and open culture, and supporting and developing staff across the trust, so that they are able to realise their potential and give of their best
BAF/Corporate Risk Register: (if applicable)	**UHD 1342** - The inability to provide the appropriate level of services for patients during the COVID-19 outbreak **UHD 1383** - COVID -19 risk relating to HCAI **UHD** (risk ref tbc) – COVID -19 impact on staffing
CQC Reference:	All domains

Committees/Meetings at which the paper has been submitted:	**Date**
Trust Board (Full report)	Nov 2020
Quality Committee (Quality)	
Finance & Performance Committee (Operational / Finance Performance)	
Trust Management Group	Nov 2020

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1– COVER SHEET

Meeting Date: Wednesday 25th November

Agenda item: 8.1

Subject:	Planning for Q3 & Q4 2020 / 21 (Winter Plan) for University Hospitals Dorset (UHD)

Prepared by:	Mark Major – Associate Director of Operations; Donna Parker – Deputy Chief Operating Officer
Presented by:	Mark Mould, Chief Operating Officer

Purpose of paper:	To request formal sign off and approval of the final iteration of the joint University Hospitals Dorset winter plan. By way of informing the Board of the system winter planning, a draft of the system surge and escalation plan is also included alongside the UHD plan. The Second Surge plan summary is presented to Board for COVD 19 surge plan presentation is for interest and awareness, noting that the planning around COVID 19 is dynamic and changing with many variables.
Background:	The Covid-19 pandemic of 2020 has placed significant pressure on the National Health. It is recognised that University Hospitals Dorset NHS Foundation Trust will face considerable and unique challenges this winter. The winter plan recognises and anticipates these unique threats and sets out the organisational response to ensure the continuation and delivery of quality services within a safe environment for patients, carers and staff alike.
Key points for Board members:	• Winter planning for 20/21 is broader than planning for surge and high demand for services: the plan this year also considers the ongoing COVID 19 pandemic and the EU transition. • The winter plan has gone through a formal assurance process with the CCG, assessing the plan against the Key Lines of Enquiry set out under appendix 5: • To note that the winter assurance framework and the core planning domains laid out below:

	<table><tr><td>Capacity</td><td>A review of available bed capacity to support winter including how non-bed based capacity can best be used to reduce avoidable admissions.</td></tr><tr><td>Demand</td><td>A bed model with expected demand across the winter period. Surges in demand are likely and there needs to be flexibility in response to these. Emergency departments must be able to maintain flow to avoid risk of nosocomial infection. Core elective activity and critical services must be maintained.</td></tr><tr><td>Workforce</td><td>Ensure that clinical and non-clinical workforce levels are reviewed and aligned with expected levels of demand and capacity. Steps must be taken to ensure all rosters are completed in good time and any workforce gaps mitigated as far as possible.</td></tr><tr><td>External Events</td><td>Consideration to both national and local factors beyond the immediate healthcare setting and the potential impacts.</td></tr><tr><td>Flow</td><td>Systems wide review of all points of interaction between services and identify any instances of friction. Where delays are identified systems must ensure clear approaches are in place to alleviate these agreed between all affected parties. This needs to include effective discharge pathways.</td></tr></table> • The plan summary document has been aligned to this assurance framework and feedback from the winter assurance exercise is anticipated; • The General and Assessment bed Capacity Plan for both sites vs bed forecast highlights an average monthly bed deficit of circa 28 and 34 beds for Royal Bournemouth site and Poole site respectively. • Several options for creating additional bed capacity are currently being worked up. • Planning includes ‘Living Alongside COVID 19.’ which incorporates and builds upon learning from the initial surge as laid out within the Second Wave slide set. • Key risks associated with the EU transition include: procurement; clinical trials; vaccines and cyber-attacks. To note the Local Resilience Forum (LRF) of which UHD is a member, continues to plan for the transition and will lead on any requirements for Dorset. • All operational issues arising from the above will be initially managed through the daily tactical meetings and escalated as appropriate. • The specialty plans in place as part of planning for Q3 and Q4 2020 / 21. • The staff support in place to help members through the next six months. • To note the staffing and workforce plan which will be critical in maintaining services and the capacity needed to meet the operational challenges this winter.
CWT)	
Recommendations:	**Members are asked to:** Note the areas of interest for discussion; note and consider the second surge planning summary and formally sign off and approve the winter plan for UHD for 2020 / 21.
Next steps:	Ongoing planning around COVID 19 will be reflected within the plan summary and can be re-presented at future Board meetings.

	A detailed operational plan is being developed for the specific Christmas holiday period and will include any intelligence published through the national incident control room i.e. specific dates where the system can expect high and exceptional demand.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	To ensure the continuation of key and critical services through readiness and preparedness for the next 6 months; To ensure the continued delivery of **quality of care** so that services are safe, compassionate, timely and responsive – achieving consistently good outcomes and an excellent patient experience; To support staff, carers and patients alike for what will be a challenging period in the history of the Trust and the wider NHS.
BAF/Corporate Risk Register: (if applicable)	**UHD 1342** - The inability to provide the appropriate level of services for patients during the COVID-19 outbreak **UHD 1383** - COVID -19 risk relating to HCAI **UHD** (risk ref tbc) – COVID -19 impact on staffing **UHD 1131** – inability to effectively place patients in the right bed at the right time (Flow) **UHD 1387** - Demand for acute inpatient beds will exceed bed capacity (Demand & Capacity) **Existing RBCH/Poole site risks (*1011, 801, 1332 – UHD ref no. awaited*)** re ED: *1) Performance; 2) Ambulance handovers; 3) Patient safety* ***Existing RBCH/Poole site risks (1053 – UHD ref no. awaited)*** *re Long Length of Stay / Discharge to Assess* **UHD - 1074** Risks associated with breaches of 18 week Referral to Treatment and 52 week wait standards **UHD – 1017** Demand for acute inpatient beds
CQC Reference:	All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	**Date**
Trust Board (Full report)	Nov 2020
Quality Committee (Quality)	Nov 2020
Finance & Performance Committee (Operational / Finance Performance)	Sept & Oct 2020
Trust Management Group	Sept 20 Oct 20 20Nov

University Hospitals Dorset
NHS Foundation Trust

University Hospitals Dorset NHS Foundation Trust
Operational Plan for Quarters 3 & 4

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1. Introduction

The Covid-19 pandemic of 2020 has placed significant pressure on the National Health Service It is recognised that University Hospitals Dorset NHS Foundation Trust will face considerable and unique challenges this winter.

Accordingly this document sets out the operational plan for quarters 3 and 4 2020/21, and the organisational response to ensure the continuation and delivery of quality services within a safe environment for patients, carers and staff alike.

Winter planning remains an ongoing and iterative process: the planning underpinning this document will increase resilience and winter readiness for both the Trust and the wider system.

This plan acknowledges other broader challenges that may further impact services over the winter months:

- The key risks associated with the EU transition;
- Ongoing impacts associated with COVID 19 pandemic including the need for social distancing;
- Seasonal demand on health and social care.

2. Approach to Winter Planning

On the 1st October 2020, Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust merged to form the University Hospitals Dorset NHS Foundation Trust. Accordingly this plan reflects an overarching organisational plan.

The planning approach to winter uses a number of core planning domains and principles as set out below, which are aligned to the wider NHS.

Table 1: *Summary of the core planning domains as set out within the winter assurance framework.*

Capacity	A review of available bed capacity to support winter including how non-bed based capacity can best be used to reduce avoidable admissions.	Section 5
Demand	A bed model with expected demand across the winter period. Surges in demand are likely and there needs to be flexibility in response to these. Emergency departments must be able to maintain flow to avoid risk of nosocomial infection. Core elective activity and critical services must be maintained.	Section 5
Workforce	Ensure that clinical and non-clinical workforce levels are reviewed and aligned with expected levels of demand and capacity. Steps must be taken to ensure all rosters are completed in good time and any workforce gaps mitigated as far as possible.	Section 10
External Events	Consideration to both national and local factors beyond the immediate healthcare setting and the potential impacts.	Section 9
Flow	Systems wide review of all points of interaction between	Section 7

	services and identify any instances of friction. Where delays are identified systems must ensure clear approaches are in place to alleviate these agreed between all affected parties. This needs to include effective discharge pathways.	

3. Key Risks & Threats

Previously recognised mitigations and 'lessons learnt' during the winter of 2019-2020 may not address the risks posed by a predicted second wave of Covid-19. Therefore, planning has also been informed by learning through Covid 1 Wave.

Meeting the clinical needs of the patients accessing our services during the winter period requires a 7 pronged approach:

1. Building on learning from previous years and during Covid 1st Wave;
2. Demand and capacity planning, including in relation to infection control policies and practices;
3. Sustainable ongoing quality and service improvements;
4. Specific planning and investment for winter capacity;
5. Clear escalation plans;
6. Communication and engagement with our staff, partners, patients and public;
7. Partnership working that secures capacity and resilience across the Dorset system.

The planning will need to remain under review throughout the winter period in order to respond to a number of identified challenges:

Table 2: *Summary of the key risks identified over the winter period.*

	Key Risk	**Mitigation plans**
1	Potential impact of 2nd wave of Covid-19 with associated risks to workforce, capacity, particularly Critical Care capacity and ongoing 'elective' and other reset/recovery plans.	See summary plans at Appendix 4.
2	Concurrent influenza	Influenza Vaccination programme in place. Pandemic Influenza Plan to be revised/updated with support from Joint Pharmacy/Staff and Midwifery teams.
3	Critical Care staffing capacity	Currently on the regional risk register. Cross Dorset approach to recruitment.
4	Having sufficient bed base to maintain the safe admission into an acute bed	Home First 'D2A,' programme. Capacity and demand bed modelling Development and implementation of bed capacity options. Expansion of SDEC services.
5	Insufficient community capacity, including for Covid patients	Home First 'D2A,' programme CQC accreditations Ringfenced Community Hospitals
7	Reduced/availability of Covid-19 tests and delays	This will be monitored via COVID –

	in turnaround times in addition to demand from discharge to care homes. The impact to discharging patients.	19 tactical command with escalation to wider system.
8	Sicker patients as a result of late referral/diagnosis and increased frailty due to shielding and immobility.	This will be monitored. Rollout of previous winters' acuity programme is under review.
9	Workforce capacity.	Workforce plan in place.
10	Demand for Primary care due to winter pressures could create additional activity within Emergency Departments.	Link to system wide plan. NHS 111 First programme (noting capacity risks). SDEC developments.
11	EU Exit risk to procurement. Potential impacts include Pharmacy.	Joint planning meeting in place to examine any residual risk from previous planning and to monitor and act upon government advice/requests for information.

This document should be read in conjunction with the following Trust policies:

- Adult Trust Capacity Plan
- Operational Pressure, Escalation and Capacity Plan
- Incident Response Plan
- SOP management of 12 hr ED Trolley waits
- Cold Weather Plan
- Outbreak plan

Departmental policies and escalation plans should also be referred to.
The Trust will be working in conjunction with system partners to ensure safe effective care for the people of Dorset

4. Phase 3 Recovery Plan

Winter planning has included a commitment to the Phase 3 recovery plan summarised below and has informed the planning assumptions for the next 6 months.

The Phase 3 plan advocates the following:

- Sustaining current NHS staffing & beds;
- Deliver a very significantly expanded seasonal flu vaccination programme;
- Dorset system should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand;
- Continue to work with local authorities, and community partners to ensure that those medically fit for discharge are not delayed from being able to go home.

Table 3: *Summary of the Phase 3 recovery plan*

	Leads
Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter	
Restore full operation of all cancer services	
Recover the maximum elective activity possible between now and winter, with clinically urgent first with the longest waiting patients as the next priority:	

• In September – at least 80% of previous years activity rising to 90% in October • 100% of last year's activity for first OP attendances and follow-ups (f2f / virtually) from Sept (aim for 90% in Aug). • To work with GP practices to ensure that every patient whose planned care has been disrupted by Covid-19 receives clear communication about their care and who to contact.
Restore service delivery in primary care and community services
From 1st Sept, RBCH and PH community health and social care providers should fully embed the discharge to assess processes as published in August 2020. Dorset CCG must resume NHS Continuing Healthcare Assessments from 1st 2020
Expand and improve mental health services and services for people with learning disability and/or autism
• Dorset CCG to increase investment; • Dorset System to validate their existing LTP mental health service expansion trajectories for 2020/21.
Preparation for winter demand pressures, alongside possible Covid resurgence
Continue to follow good Covid-related practice to enable patients to access services safely and to ensure appropriate protection for staff: • Continue to follow PHE guidance on defining and managing communicable disease outbreaks; • Continue to follow PHE/DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency; • Ongoing application of PHE's infection prevention and control guidance; • Ensuring NHS staff and patients have access to effective PPE.

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5. Approach to Bed Planning - Capacity and Demand

COVID 19+ pandemic has challenged historic planning assumptions that underpin winter planning, including planning around a reduced bed based to support socially distancing across wards. A summary of bed reductions is summarised below, which includes those beds that have been re-purposed to provide non-bed based care (SDEC) and additional critical care capacity.

Table 3: *Summary of the Phase 3 recovery plan*

BED LOSS AS COMPARED TO WINTER 2019 / 20	
Poole Hospital Site	
Beds lost to maintain safe distance	44
Additional Critical Care capacity	14
GP Assessment Area	4
J4 Trolley area	4
Total	**66**
Positive bed Loss / repurposed	
SDEC Schemes	3
Royal Bournemouth Hospital Site	
Beds lost to maintain safe distance	27
Derwent (open for 'super green' surgery only)	29
Eye Unit conversion to day case (opened in response to escalation)	0
Cardiac inpatient capacity	15
Total	**71**
	137

A number of different planning scenarios have been used to determine the number of beds needed to remain within 92% bed occupancy, as advocated for within the Operating Framework for 2020 / 21. These scenarios are summarised by site below under tables

Table 4: *Summary of the different scenarios used to model the bed requirements for winter.*

Bed Modelling - Worked through 4 scenarios across both sites

Forecast Core Capacity

1. 92% Occupancy 0% Growth
2. 92% Occupancy, 100% delivery of Home first 0% Growth
3. 92% occupancy 50% delivery Home first , 3.5% growth in non-elective
4. **92% occupancy Phased efficiency of home first, 1% growth in non – elective activity**

The following tables provide a summary of capacity vs demand and the bed deficit by scenario. Modelling has incorporated a number of planned 'winter' beds on the basis of Mth 7-12 financial allocations.

Table 5: *Bed capacity and demand for Royal Bournemouth Hospital site*

		Oct	Nov	Dec	Jan	Feb	Mar
A: CAPACITY	Forecast Core Capacity	414	414	411	425	425	425
B: DEMAND (History repeating)	Baseline Average Bed Demand based on that observed in 2019/20	437	445	448	466	460	436
Baseline Scenario	Beds required to remain in within 92% occupancy with 0% growth in B	475	485	488	506	500	474
	Additional Bed Requirement to A	61	71	77	81	75	49
1	Beds needed to remain within 92% occupancy & 100% efficiency gain through D2A model; 0% growth	453	437	442	455	450	417
	Additional Bed Requirement to A	39	23	31	30	25	-8
2	Beds needed to remain within 92% occupancy & 50% efficiency gain through D2A model; 0% growth	464	461	465	481	475	445
	Additional Bed Requirement to A	50	47	54	56	50	20
3	Beds needed to remain within 92% occupancy & 50% efficiency gain through D2A model; 3.5% growth in non elective activity	479	477	480	498	491	461
	Additional Bed Requirement to A	65	63	69	73	66	36
4	Beds needed to remain within 92% occupancy & phased efficiency gain over 6 month period, through D2A model; 1% growth	469	460	460	475	465	455
	Additional Bed Requirement to A	55	46	49	50	40	30
Other Considerations							
SDEC	SDEC Efficiency gains	-10	-10	-10	-10	-10	-10
Unplanned Winter Capacity	C4SAU				-1	-1	-1

Table 6: *Bed capacity and demand for Poole Hospital site*

		Oct	Nov	Dec	Jan	Feb	Mar
A: CAPACITY	Forecast Core Capacity	509	505	518	530	530	530
B: DEMAND (History repeating)	Baseline Average Bed Demand based on that observed in 2019/20	531	545	541	571	556	567
Baseline Scenario	Beds required to remain in within 92% occupancy with 0% growth in B	576	592	588	620	602	614
	Additional Bed Requirement to A	67	87	70	90	72	84
1	Beds needed to remain within 92% occupancy & 100% efficiency gain through D2A model; 0% growth	538	550	550	573	558	562
	Additional Bed Requirement to A	29	45	32	43	28	32
2	Beds needed to remain within 92% occupancy & 50% efficiency gain through D2A model; 0% growth	557	571	569	597	580	588
	Additional Bed Requirement to A	48	66	51	67	50	58
3	Beds needed to remain within 92% occupancy & 50% efficiency gain through D2A model; 3.5% growth in non elective activity	574	592	590	619	602	611
	Additional Bed Requirement to A	65	87	72	89	72	81
4	Beds needed to remain within 92% occupancy & phased efficiency gain over 6 month period, through D2A model; 1% growth	560	572	566	593	573	578
	Additional Bed Requirement to A	51	67	48	63	43	48
Other Considerations							
SDEC	SDEC Efficiency gains	-10	-10	-10	-10	-10	-10
Unplanned Winter Capacity	W21		-19	-19	-19	-19	-19

Table 7: *Bed capacity and demand for University Hospitals Dorset*

		Oct	Nov	Dec	Jan	Feb	Mar
A: CAPACITY	Forecast Core Capacity	923	919	929	955	955	955
B: DEMAND (History repeating)	Baseline Average Bed Demand based on that observed in 2019/20	968	990	989	1037	1016	1003
Baseline Scenario	Beds required to remain in within 92% occupancy with 0% growth in B	1051	1077	1076	1126	1102	1088
	Additional Bed Requirement to A	128	158	147	171	147	133
1	Beds needed to remain within 92% occupancy & 100% efficiency gain through D2A model; 0% growth	991	987	992	1028	1008	979
	Additional Bed Requirement to A	68	68	63	73	53	24
2	Beds needed to remain within 92% occupancy & 50% efficiency gain through D2A model; 0% growth	1021	1032	1034	1078	1055	1033
	Additional Bed Requirement to A	98	113	105	123	100	78
3	Beds needed to remain within 92% occupancy & 50% efficiency gain through D2A model 3.5% growth in non elective activity	1053	1069	1070	1117	1093	1072
	Additional Bed Requirement to A	130	150	141	162	138	117
4	Beds needed to remain within 92% occupancy & phased efficiency gain over 6 month period, through D2A model; 1% growth	1029	1032	1026	1068	1038	1033
	Additional Bed Requirement to A	106	113	97	113	83	78
Other Considerations							
SDEC	SDEC Efficiency gains	-20	-20	-20	-20	-20	-20
Unplanned Winter Capacity	Ward 21 & C4 SAU		-20	-20	-20	-20	-20

Scenario 4 as laid out is the most likely scenario and has therefore been used as the basis for further planning. The table below compares the number of beds needed to remain within 92% occupancy and the bed demand forecast underpinned by the planning assumptions described above.

A further efficiency gain associated with the plans to expand SDEC has been built in together with any unplanned physical bed capacity.

SITE	OCT	NOV	DEC	JAN	FEB	MAR
RBCH	41	38	19	34	14	19
PHF	45	36	39	39	29	19
TOTAL	**86**	**74**	**58**	**73**	**43**	**38**

The summary demonstrates an average monthly bed deficit of 24 & 34 for Royal Bournemouth site and Poole site, respectively.

6. Mitigating the Bed Deficit

Several work-streams have been established to work through a number of solutions to mitigate forecast bed deficit:

- System wide transformation programme 'Home First,' which includes the implementation of the new Dorset wide D2A model. This will provide a bed gain through greater optimisation of length of stay for patients by moving the assessment process 'out of hospital.' This efficiency / bed gain has been factored into the bed

modelling which assumes a phased delivery over the next six months. Delivering this programme is critical in ensuring the bed gap is not greater than that set out within tables 5, 6 & 7.

- Four options for creating additional bed capacity across both sites is being worked through. Estate limitations on both sites limit the options available and the timescales for completion which are being worked through.

Specialty Plans

Directorates are engaged in local bed planning to identify schemes that will further reduce occupied bed days (OBDs) through reductions in LOS or admission prevention. There are a number of 'winter schemes,' aimed at delivering a number of key objectives and the aims set out within the Phase 3 Recovery Plan:

- Additional planned bed capacity in place to meet seasonal variation in demand;
- Expansion of non – bed based services to prevent avoidable admissions into acute beds;
- Continued development of flow management system tool, 'Health of the Ward,' across both sites;
- Plans in place to provide greater resilience for the Emergency Department and assessment areas, increasing medical processing power / senior decision making and out of hours cover.
- Optimising weekend discharges to improve flow across the 7 – day period;
- Identifying new ways of working across both sites to provide mutual aid and to increase resilience.
- Outlying teams will be established to ensure minimum impact to those patients residing outside of specialty and outliers will be monitored via the daily Operations meetings across both sites

7. Optimising Length of Stay Through Improving Patient Flow

The following section outlines the work being undertaken to fully optimise and improve length of stay (LOS) for patients. Lower LOS provides additional bed capacity and improves access to acute beds for patients needing acute care.

Criteria Led Discharge

Criteria Led Discharge (CLD) is less widely used than nurse led discharge which is currently adopted within some areas of the hospitals. CLD presents a greater opportunity to help increase weekend discharges and areas struggling with medical cover. Transformational work is currently being undertaken to improve the process and awareness of CLD. The CLD policy has been written, including competency sign off. A pilot site within Older People's Services (OPS) has been identified to commence a 4 week PDSA in September. Assistance with the roll out of CLD to improve engagement – post the pilot- would be advantageous and ECIST have approached the Trust with an offer of help.

Criteria to Reside

'Criteria to Reside,' provides the medical workforce with a framework for delivering ongoing medical interventions in a sub-acute setting, reducing length of stay within acute hospital beds. This is a high priority within the Hospital Discharge Guidance to ensure Acute Trusts are able to maintain capacity for those patients requiring an inpatient stay. ECIST and the D2A Implementation Board will be supporting specialities across the Trust to access alternative services such as SDEC, Community Hospitals and follow-up by community-based clinicians to enact the Criteria to Reside methodology.

Home First – Discharge to Assess
The Dorset system has embarked on a transformational programme to implement a new discharge model. This includes a variety of support mechanisms for patients to deliver an efficient and responsive Discharge to Assess (D2A) model that supports patients to leave hospital who no longer need to reside within acute care.

Weekly ward level long length of stay reviews
Weekly ward LLOS reviews are in place to help unlock barriers to discharge and to ensure plans are in place for patients requiring acute care.

Same Day Emergency Care
UHD were awarded capital to help develop Same Day Emergency Care (SDEC) services across a number of specialties. Several capital developments are in flight and are scheduled to complete by mid-January 2021. These schemes will expand existing services aimed at avoiding admissions by providing patients with a more appropriate care setting.

8. Daily / Weekly Planning Touchpoints

There are a number of mechanisms in place throughout winter to help manage the operational delivery of acute services and patient flow.

Safety Huddles and Operational Meetings
Twice daily Operational Flow & Safety meetings (OFSM) at both sites provide a forum to review the site situation; understand the live and current pressures, and to put in place plans / actions to ensure access to beds and to mitigate against any issues impacting services. There is a multidisciplinary attendance involving the following:

Clinical Manager
Senior site lead for the day (e.g. Matron for Flow/Head of Operations/Care Group lead)
Representatives from Care Groups
ED Representative
ICT Representative
Estates Representative (as required)
Pathology/Diagnostics Representative

At times of increased OPEL pressure DCOOs / COO also will attend.

This meeting acts as an information sharing and escalation forum for key areas that need to be supported in a timely manner.

Organisational Tactical Meetings
Tactical meetings attended by senior leads take place daily with a focus on COVID related issues. This meeting will inform and escalate to Silver Command (see section 9)

System Tactical Meetings
A three-times weekly system tactical meeting will be in place from the 1st November 2020. This is a forum for partner organisations to raise operational issues and impacts and to identify and agree actions.

Winter Room

From the 1st November 2020 Dorset CCG will partner with Southwest Ambulance Trust (SWAST) to establish a winter room to help manage winter. Its role will be multi-factorial:

- To provide intelligence to partners to support operational planning;
- To support the system-wide escalation process;
- To provide wider reporting across urgent and emergency care.

9. External Events

COVID 19 Pandemic

The ongoing impacts of the COVID 19 pandemic and the prospect of a second wave necessitate the need for robust planning within an ever changing landscape.

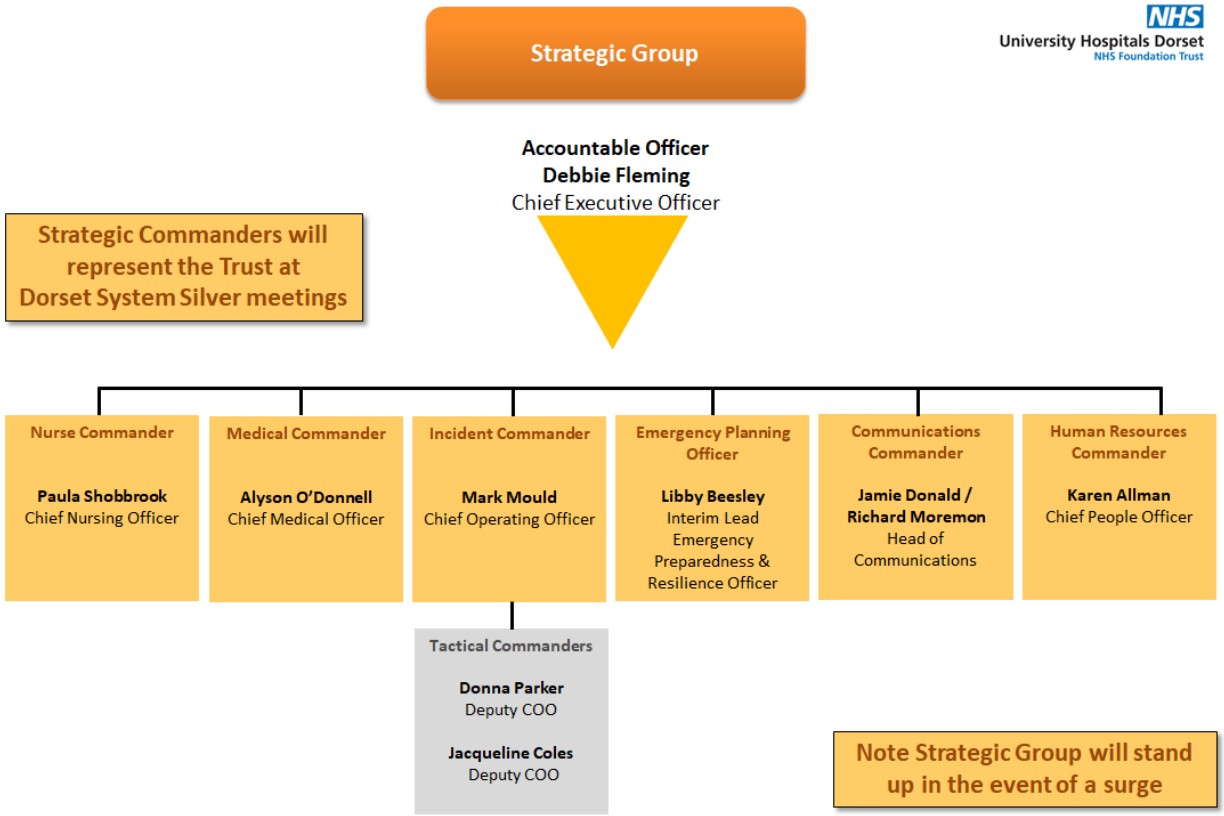
The following are the key principles that underpin second wave COVID 19 planning across UHD:

- Approach to Supplies and Medicines as per 1st Wave;
- Maintenance of separate Medium/High risk pathways in Emergency Departments with escalation to separate areas and high/medium risk Resuscitation areas;
- Blended admission units, with separate Low, Medium, High risk pathways, until trigger to separate High – Low Risk units;
- Maintaining speciality pathways until 'trigger' to mixed speciality;
- Maintaining acute specialist pathways (e.g. acute GI, Cardio) using side rooms/cohorting;
- Escalation plan from side room, to bay cohort, to identified High/Medium risk ward/s (*moving to East Wing at RBCH* site);
- Critical Care escalation plan agreed across both sites and local Network;
- Preserve outpatient and elective capacity wherever possible to support Phase 3 recovery plan (*eg. Derwent and RBCH - W12 'super green*') - phased de-escalation of elective capacity based on triggers;
- Patients to attend hospital only when really necessary (tele-med/videoconferencing);
- Nursing escalation plan;
- Preserve training and education as far as possible;
- Well established HR guidance, including for staff testing and isolation, available via Trust intranet and remains under review if/as further national guidance is released;
- Staff risk assessments undertaken and remain under regular review, especially for vulnerable/higher risk staff;
- Recognition of the impact on our staff – well established wellbeing support continues (see staff and wellbeing section 11);
- Support national and system protocols that maintain safety in Care Homes;
- Swabbing/testing is based on a portfolio of platforms to maintain resilience;
- Swabbing/testing moving closer to clinical pathways where environment allows;

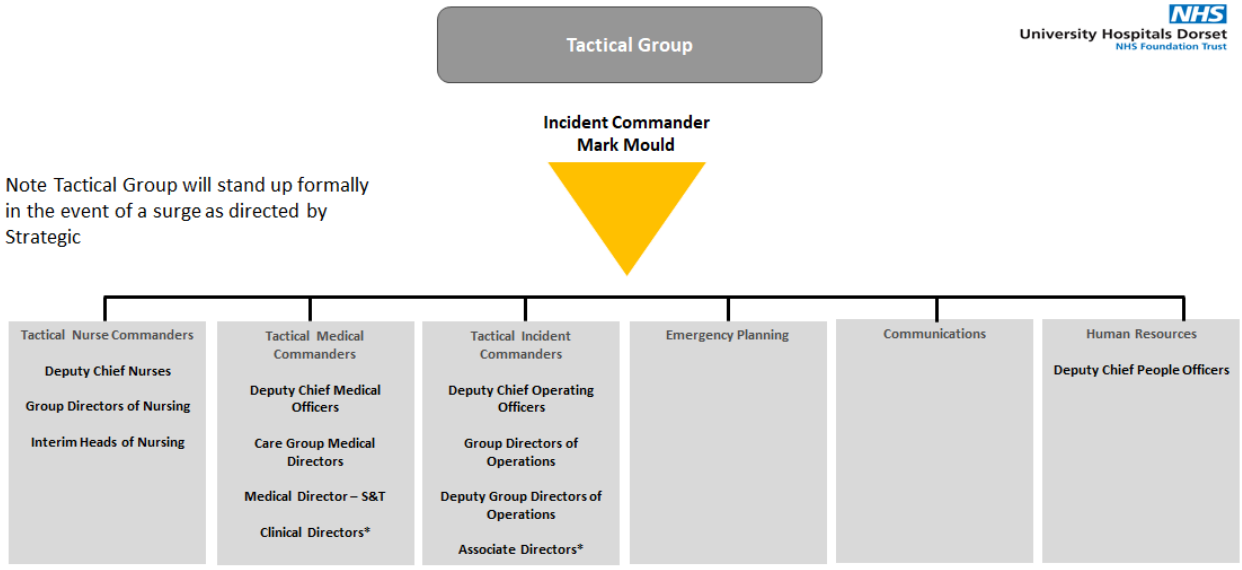
In line with phase 3 reset letter and during periods when managing COVID-19 is stable, the Tactical Group will take on the role of the Incident Coordination Centre in managing operational services across all sites in order to:

- To receive information and escalation reports from Operational Cells, Tactical will review and take decisive action as required;
- To receive information and escalation reports on operational patient flow, to review and agree flow plans to ensure they are operationally and COVID-19 safe;
- To share COVID-19 related matters and maintain communication with Care Groups and Corporate Services when required;

- To manage the COVID-19 related communications;
- To support the implementation of changing national and clinical guidance in relation to COVID-19;
- To act as a conduit for communication between local and system meetings in response to managing services during the COVID-19 pandemic;
- **To escalate any COVID-19 related key issues or risks to Strategic Commanders using the escalation briefing form when required.**



The Strategic Group will stand up in the event of a surge as required



EU Transition

The UK exited the EU on the 31st January 2020 and is now in a transition period until 31st December 2020. EU and UK negotiations have so-far failed to finalise a deal, and discussions are taking place centrally to advise on arrangements from this point onwards. Nationally, regionally and within University Hospitals Dorset, the EU Transition is being treated as a concurrent incident to Covid-19 and managed by the Command and Control structures already in place.

A joint UHD EU Transition task and finish group has been set up and is a sub set of the joint Emergency Planning Group, with the remit of management and mitigation of risks; the coordination of actions required for assurance, monitoring the implementation of recommendations and plans and monitoring and escalating any financial consequences of EU transition.

The Dorset Local Resilience Forum is leading on the multi-agency response and the Lead EPO attended a table top exercise looking at concurrent winter risks, including EU transition.

Risks identified for UHD include

- the supply of medical devices and consumables;
- supply of medications;
- blood supplies and other human origin products;
- supply and cost of food;
- supply of other products/contracts;
- workforce;
- research and development;
- travel disruption;
- reciprocal healthcare arrangements and data sharing.

There may also be risk for the Poole hospital site and traffic congestion around Poole port.

10. Workforce Recruitment & Escalation Plans

All departments will have in place robust annual leave arrangements, particularly over the Christmas/New Year period. The organisation expects and therefore is planning for an increase in staff sickness during the winter months. Both sickness and vacancies are regularly monitored, at a department level and Trust wide to ensure full support to staff members and to ensure services remain operational.

Workforce remains a significant risk to winter planning. Safe staffing will be maintained through use of existing ward workforce (potential re-deployment) and specialist staff with the use of bank and agency where necessary.

Workforce Recruitment & Escalation Plans - Nursing

- External recruitment process commenced for the winter escalation areas.
- Working up the opening of 4 additional escalation areas across UHD this includes Wards 21, 14 and 8 on the RBH site and Lilliput on the PGH site (14 beds due to open January). C2 Poole site now open and staffed with 12 additional beds.

- Plans to staff escalation areas with a mixture of Trust staff allocated from other ward areas, `long lines' of booking and bank and agency. Dependent on uptake there will need to be a consideration to reduce elective work to repurpose specialist nurses to staff areas.
- Staffing needs to also be triangulated against CHPPD hours to increase bed base and maintain patient safety. This will be multifactorial and needs to be considered at a tactical level on a risk basis, there is a document to support reduced levels of staffing endorsed by the trust. (A Guide to safe staffing of inpatient areas during Covid-19).
- Phased staffing plans in place for escalation of ITU's on both sites where nurses will be moved back to ITU according to the escalation level/prevalence of Covid -19 at the time.
- Downstream staffing will be affected at ITU escalation trigger level 2/3 as a second ITU opens on either site. Elective services will be impacted upon at trigger level 2/3 with both ITUs open in two areas and full with level 3 patients.
- There will be a requirement to flexibly respond to changes in Covid-19 patient numbers according to local demographics.

Managing this evolving clinical footprint, whilst maintaining staff morale, patient safety and satisfaction is complex; requiring both flexible and sustainable solutions.

The staffing templates are being developed using standard processes and financial costing's worked up on the following basis:

a. One third of staff to be redeployed from across the Trusts, including the Band 7 and 6 nurses.
b. One third of staff to be sourced through agency long lines of work.
c. One third of staff to be provided through standard recruitment processes or backfilled with bank staff.

The staffing for ward C2 (PH) will be covered by the re-positioning staff from B2.

Bespoke advertisements and training support programmes are planned for specialist areas where additional staffing is required as a result of estate changes; for example the Emergency Department and Critical Care.

Utilisation of Tier Two agency long lines of work for the Emergency Department to off-set existing premium agency costs has begun. If successful the scheme will be rolled out to other appropriate areas.

As the opportunities for our existing volunteers to return to the hospital post Covid-19 open up the Trust is reviewing new roles where this essential workforce can be utilised to support care. Recruitment to expand this essential support resource has also begun.

Daily safe staffing meetings where the Matrons report in with regards to reviewing up-coming clinical staffing levels and any adjustments / additions that may be required, based on clinical acuity or demand.

Workforce Recruitment & Escalation Plans - Medical

RBH Site

- Plans being finalised for medical cover for Medium/High risk ward (W14) on 6/10/20

- Plans are being reviewed for medical cover for East Wing and/or further Medium/High risk wards and subject to single or mixed speciality model
- Plans being worked up for medical cover for winter/additional RBH site wards: W21, W14 and potentially W8
- ICU have modelled up to 24 beds without significantly affecting other medical rotas.

Poole Hospital Site
- Escalation plans being finalised
- Winter escalation ward (OPS) already modelled
- ICU – escalation to 19 beds will not significantly affect rotas but some key nursing staff have been identified who would be called upon and this has been shared with matrons from the respective areas

General
- Model for medical cover (e.g. mixed speciality Team approach, escalated rotas for enhanced senior and other cover) is being reviewed by DCMOs and GMDs
- Aim to have more flexible, phased approach to escalation/change in rotas
- Plan to preserve elective activity and pathways

Workforce Recruitment & Escalation Plans

The following commenced in Covid-19 1st wave and continues to support monitoring and response should the trust experience a 2nd wave:

- Workforce reporting;
- Recruitment of supplementary workforce;
- Covid related HR advice – full guidance available on Trust intranet;
- Staff risk assessments across the trust, including for vulnerable staff;
- Covid related induction and training;
- Enhanced Health and well-being support including support for staff shielding and for staff from a BAME background.

HR Cell to continue to work on plans, including:

- Promoting the Covid-19 hotline to support with staff enquiries regarding quarantine, self-isolating, any school closures and staff swabbing – all in Q & As, but reassurance and guidance needed.
- Staff accommodation for anyone needing to isolate away from their household needs to be considered. OH planning to review risk assessment process

With the increased levels of Covid-19 in the community the Trust is seeing a rise in the numbers of nursing staff either off sick, self-isolating , shielding or repurposed. With the current levels safe staffing has been maintained using our existing trigger systems:

- Red-flags measurements
- Acuity and Dependency Monitoring using SafeCare
- Professional Judgement
- Minimum levels of acceptable staffing
- Quality matrix monitoring
-

Learning from the national picture plans are in place to review our local triggers and adjustments to care levels to deliver only basic nursing care if staffing levels were to be compromised, for example:

- Delivering on essentials such as medicines, hydration, nutrition, wound care and toileting
- Reducing admission paperwork to basics, omitting property assessments
- Omitting some assessment tools such as frailty scoring / dementia assessment
- Routine patient rounding reduced only to those at high –risk
- Adjusting eNa frequencies around observation levels.
- Dependent on uptake there will need to be a consideration to reduce elective work to repurpose specialist nurses to staff areas
- Funding received of circa 25K to support expediting the recruitment of 15 international nurses across both sites, with further funding from HEE received to support enhancing the OSCE training for all international nurses working towards registration.

11. Staff Wellbeing

A multi-specialty working group has continued to meet since the lockdown eased. Additional resource has been allocated within the UHD OD team to develop an holistic Staff Wellbeing package with stakeholders. Work streams are being progressed across several areas in line with national recommendations;

- Leadership and culture;
- Engagement and evaluation;
- Healthy environment;
- Physical wellbeing;
- Healthy lifestyles;
- Psychological wellbeing.

Our Covid-19 2nd phase package includes an enhanced Psychological and Emotional Support package supporting staff through uncertainties over the next 6/12 months:

- To continue with 12 months of additional resource for those in need of emotional support;
- Working alongside BAME network colleagues to provide additional support, including risk assessments;
- Bespoke team resilience support available and being accessed

Safe Spaces

- Planning around establishing safe spaces for staff members;

Food and Hydration

- Coordinated effort to provide access to food and hydration will be ramped up as required

Staff Engagement and Involvement

- Intranet and communications will deliver current on messages and latest advice & guidance;
- Wellbeing hubs on all sites will be re-vamped providing central information points and someone to talk to.

Influenza

The Trust will be reviewing practice against the national guidance with a view to achieving full compliance. A joint Trust wide Flu Vaccine Coordination Group has been established to oversee the programme. All sites will aim to build on work last year:

- Board commitment ambition to achieve 100% staff vaccination;
- Nationally recommended flu vaccine will be ordered and provided for healthcare workers;
- Anonymous collection of data on reasons for staff who decides against uptake;
- Full communications plan in place;
- Drop in clinics, 24 hour mobile vaccination schedule and flexible 'bleep' service;
- Department based trainers;
- Reviews of appropriate practice to support uptake in higher clinical risk areas.

Progress will be regularly reported to the Joint Trust Board.

Management of any outbreak of Covid-19 and/or influenza will be coordinated through the South West Region, Health Protection Team of Public Health England. Public Health Dorset and Dorset CCG will maintain communications with the Trust via the Infection Control Team.

Please see merged Outbreak Plan.

• Escalation Plans

The Operational Pressures Escalation Levels (OPEL) is a nationally mandated monitoring system that sets out a formal and transparent approach to the state of departments and the Trust. This improves consistency and speed of response in escalation and ensures the right people are supporting recovery plans. There continues to be an opportunity to refine our approach internally, linking into the system resilience process.

The Trust's Operational Pressures Escalation and Capacity Plan are expected to be updated following Covid-19 by DHSC. This will inform the Trusts' OPEL plan to reflect the support other hospital sites can provide.

NHSEi have confirmed that Trusts can declare OPEL 4 separate to the Dorset system, after Executive level discussion with the CCG.

To this end the system wide escalation planning is currently under review by the Dorset Urgent and Emergency Care Board to ensure an effective and swift response to Opel 3 / 4.

9. Communication and Engagement

There has been a series of presentations of the winter plan across both sites. A comms plan will be developed to ensure regular updates throughout the winter period, including in the Core Brief, Staff Bulletin and other media (e.g. screensavers, posters, targeted emails, SMS messages and social media).

This paper will be submitted to the Trust Management Board and Board of Directors. It remains an iterative plan and further updates will be provided by exception to both committees over the remainder of 2020/21.

Communications to patients and public

Communications to patients and public are led by the Dorset CCG, working jointly with partner communication leads.

Dorset System wide communication aims for winter 2020-21 are to:

- Change public behaviour through providing advice and guidance to other health services to prevent pressures on the urgent and emergency care systems during the winter period;
- Build awareness of the work implemented to be prepared for the winter period;
- Ensure the health and care system responds to all reputational issues associated with performance during the winter period in a coordinated and credible way.

Key Messages

- The public can help the local health and care system to cope with winter pressures by taking steps to keep themselves well, such as taking up the flu jab when offered and seeking advice at the first sign of illness.
- Both staff and patients must continue to be reminded about the need to social distance and wear masks at all times when in public areas of the hospital.
- People can also help by using the right service for their needs and seeking advice from NHS111 and Dorset CCG website.
- Prompt discharge from hospital is an especially high priority for the local health and care system during the winter period and people can support this by making sure that loved ones in hospital are helped to return home as soon as they are fit and able to do so.
- The Public will also be encouraged to use the Waitless app.

Communication mediums include:

- Social media (Twitter, Facebook);
- Local print and broadcast media, via press releases and story generation;
- ‘Stay Well this Winter’ media campaign
- Websites.

10. System Resilience and SITREP Reporting

Multi-agency Bronze meetings will take place over the winter in order to;

- Provide intelligence to the system in terms of demand over a 24 – 48 period (SWAST);
- Articulate any pressures or issues that are likely to have a system wide impact;
- To agree mitigating steps;
- To provide a summary to Silver with any recommendations or escalations.

These safety and planning huddles will be increased to daily when demand increases. In addition, the established process for calling an extraordinary teleconference via Single Point of Access (SPoA) will be available. Resilience alerts can be submitted at any time by partner organisations via the SPoA.

Daily Sitreps (indicating operational pressures, performance, ED diverts, cancelled operations etc) will be collected from the NHS Improvement web portal – these will be signed off by the Deputy COO or nominated deputy on behalf of the Chief Operating Officer. Arrangements will be reviewed as required for any weekend/bank holiday reporting.

Christmas/New Year (and other peak holiday periods)

Specific operational plans will be developed for the Christmas/New Year period across all hospital sites due to the expected surge of patients attending hospital following the bank holiday periods. This will detail department plans, contacts, and staff availability, reporting responsibilities and management oversight for each day; reporting in line with OPEL and assurance on plans for:

- Christmas & Bank Holidays - Senior Leadership presence
- On- call support
- Daily Situation reports responsibilities.

It is expected that departments will provide enhanced services over the following days:

Christmas Eve – 24th December
29th/30th/31st December

And any other dates indicated by ambulance service peak projections.

Emergency Preparedness

The Trust's Winter Plan should also be read in conjunction with relevant Emergency Preparedness policies and plans. In particular the Cold Weather Plan lists the actions to be taken in times of extended cold weather and the effect on patient conditions.

The Trust is required to respond to a major or internal incident at any time, including when the hospital is experiencing capacity challenges.

The Interim Lead Emergency Preparedness Officer (EPO), as EU Exit Lead continues to work with the Operations team to ensure anticipated impacts related to the EU Exit are understood.

In addition to this, the EPO leads on severe weather planning. This remains as a risk on the risk register due to the potential to impact services, along with mitigating factors.

11. Partnership Working

As Dorset partner winter plans are shared, these will be reviewed considering potential impact and/or opportunities. Key existing areas of current partnership working include:

- Home First Board
- Silver Command
- Discharge to Assess Dorset Model
- Urgent and Emergency Care Board
- Collaboration with East Cluster and East Integrated Health Care Partnership (all partners) locality based meetings, supporting development of ICPCS/Primary Care Network projects
- Elective Care Board
- Integrated Urgent Care Service partnership – exploring potential for rotational staff
- Consultant Connect advice & guidance for GPs and potentially paramedics

Social care and capacity across community services remains a risk for the winter period, particularly during holiday season.

12. Governance, Monitoring and Reporting

The strategic and operational teams will regularly review metrics to aid 'horizon scanning' of issues through the winter, escalation and response. Metrics include:

- Number of Covid-19 patients, Covid-19 patients in ITU, Covid related deaths
- Time to decision to admit / discharge, mean time, DTA to admission (ED)
- Over 14, 21 day LoS
- Number of patients who do not meet Criteria to Reside (including those over 21 days)
- Same Day Emergency Care activity
- ED attendances and ambulance conveyances
- Activity and occupancy levels (92% max, 88% stretch) against predictor
- NEWS (acuity)
- Readmissions
- Cancelled on the day admissions
- Outliers out of the care group
- Days at OPEL 3 and 4
- SIs, LERNs, mortality
- 111 and UTC streaming capacity
- ITU bed days and delays
- Staff absence (including for Covid related reasons)

Monitoring will take place through the following internal groups/committees:-

- Daily site meetings
- Trust Management Group (meets on a fortnightly basis)
- Operations and Performance Group (meets weekly)

The 24/7 leadership arrangement for the Trust include an on-call manager on both sites and Joint on call Executive. These teams are cited on escalation to Dorset CCG where appropriate.

As well as internal groups, progress will be overseen by the Dorset Urgent & Emergency Care Delivery Board.

APPENDIX 1 – Care Group Winter Plans

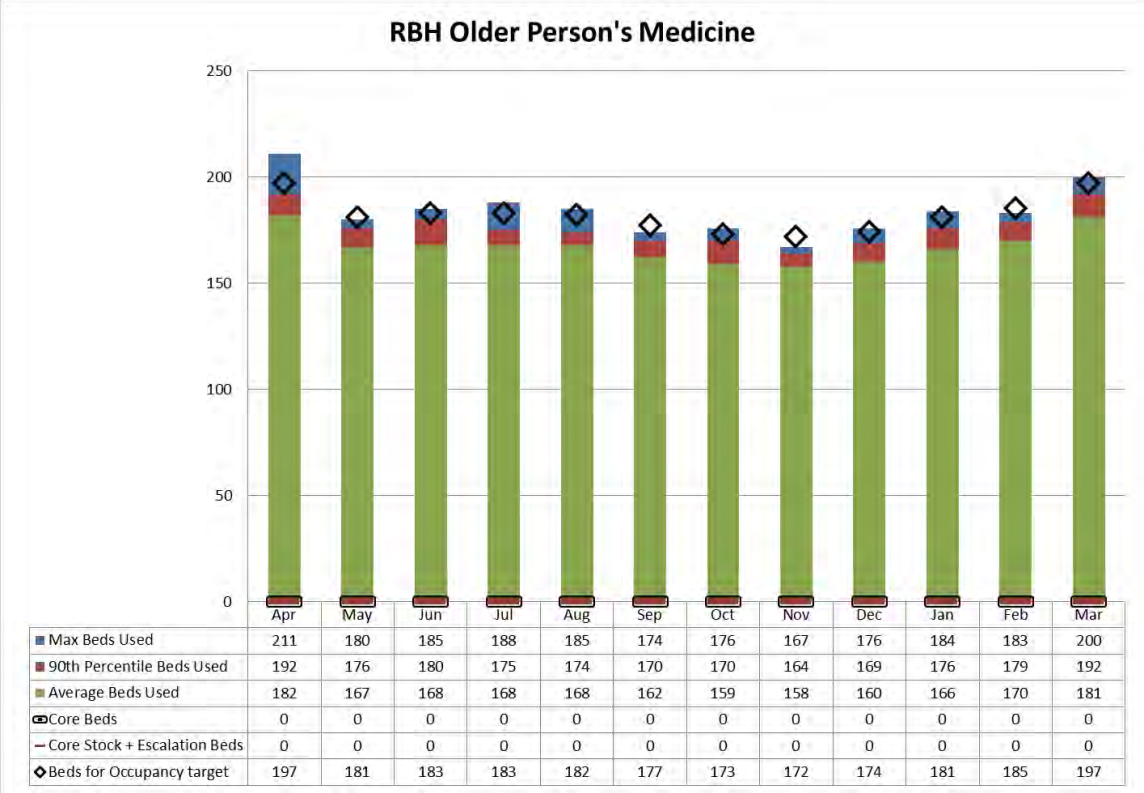
Overarching principles expected within all plans are:

- Support for higher acuity and patient safety;
- Phased capacity (including annual leave planning) to ensure optimum 7 day cover over winter/peak periods;
- 'Step up' of capacity and particularly in lead up to Christmas ('Home for Christmas');
- Optimising MDT working;
- In reach to front door areas;
- Advice and guidance to primary and community colleagues;
- Same Day Emergency Care (ambulatory unless proven otherwise);
- Bed capacity as per below plan;
- Escalation plans in place and well communicated within teams;
- Training in Discharge and Leaving Hospital policies prioritised for key staff;
- Collaborative work with partners.

Frail & Elderly Services

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Max Beds Used	166	161	157	151	150	152	168	167	168	202	181	176
90th Percentile Beds Used	153	153	151	150	148	147	162	164	162	188	174	168
Average Beds Used	140	143	143	138	140	137	150	154	152	178	163	151
Core Beds	0	0	0	0	0	0	0	0	0	0	0	0
Core Stock + Escalation Beds	0	0	0	0	0	0	0	0	0	0	0	0
Beds for Occupancy target	153	155	155	150	152	149	163	168	166	194	177	164

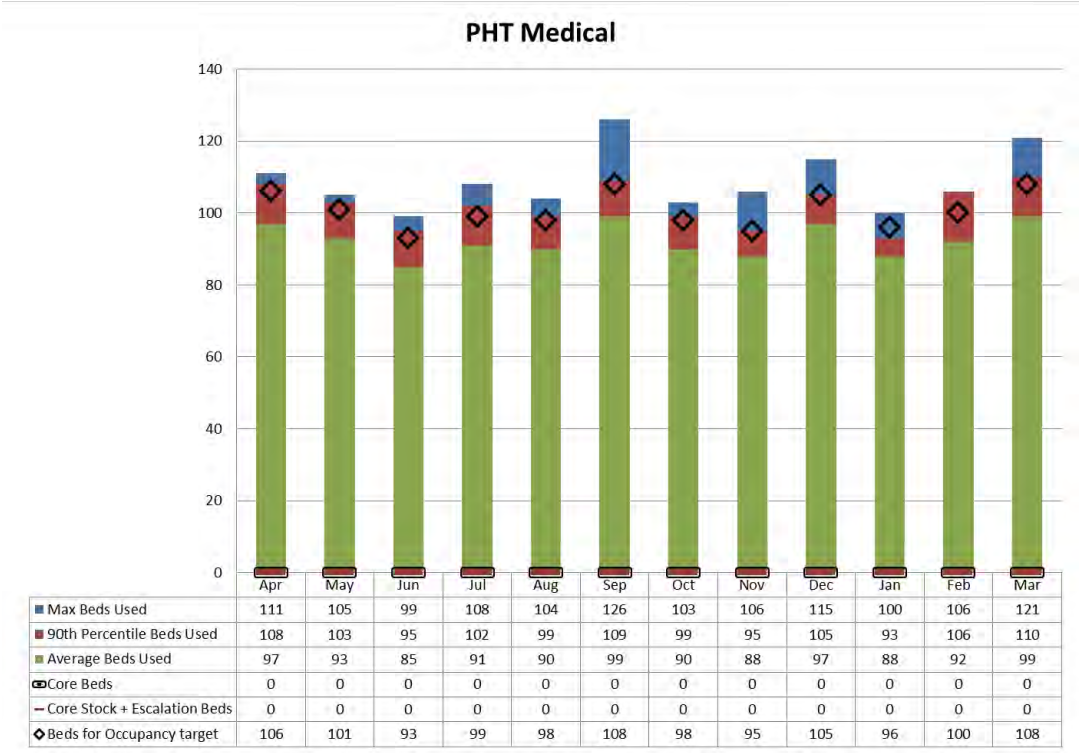
PLAN	BENEFIT / OUTCOME	GO LIVE DATE
OPS PH Site		
Increased Same Day Emergency Care capacity on RACE.	**ADMISSION PREVENTION:** Increased number of admissions prevented through increased use of ambulatory care.	1st January 2021
Outlier team assembled to support patients residing outside of specialty.	**LOS OPTIMISATION** Optimised LOS through dedicated team, including consultant, ANP and discharge support	1st October 2020
Operationalizing Lilliput ward area to provide additional DME bed capacity. Plan to use beds for patients who are medically ready to leave and no longer meet the criteria to reside.	**BED CAPACITY** Area to mitigate against discharge delays to maintain flow through frail and elderly bed base	1st January 2021
Extension of current funded escalation bed capacity on Kimmeridge.	**BED CAPACITY** To provide additional bed space to offset, in part, bed capacity lost to ward distancing	1st October 2020
One session per week of Geriatrician support to ED	**FRONT DOOR RESILIENCE** Senior Geriatrician decision maker at front door to prevent unnecessary admissions and to strengthen connections between ED and	October 2020
Home intravenous service	**ADMISSION PREVENTION** ANPs providing a community home intravenous service for patients who would otherwise be admitted to hospital. Trial to understand benefit and whether future service could be supported by the community.	Tbc
Same Day Emergency Care for Pleural conditions	**ADMISSION PREVENTION** SDEC area to provide urgent support for respiratory patients who would otherwise be admitted into the Trust	December 2020
ANP care/nursing home outreach	**ADMISSION PREVENTION**	Tbc



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Max Beds Used	211	180	185	188	185	174	176	167	176	184	183	200
90th Percentile Beds Used	192	176	180	175	174	170	170	164	169	176	179	192
Average Beds Used	182	167	168	168	168	162	159	158	160	166	170	181
Core Beds	0	0	0	0	0	0	0	0	0	0	0	0
Core Stock + Escalation Beds	0	0	0	0	0	0	0	0	0	0	0	0
Beds for Occupancy target	197	181	183	183	182	177	173	172	174	181	185	197

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
OPSRBCH Site		
New Frailty Unit	**OPTIMISED LOS** New Frailty short stay unit in place to provide dedicated support to the frailty.	
Dedicated SDEC area for frail elderly	**ADMISSION PREVENTION** SDEC for the frail and elderly to prevent admission and support patients continuing to reside within their usual place of residence	September 2020

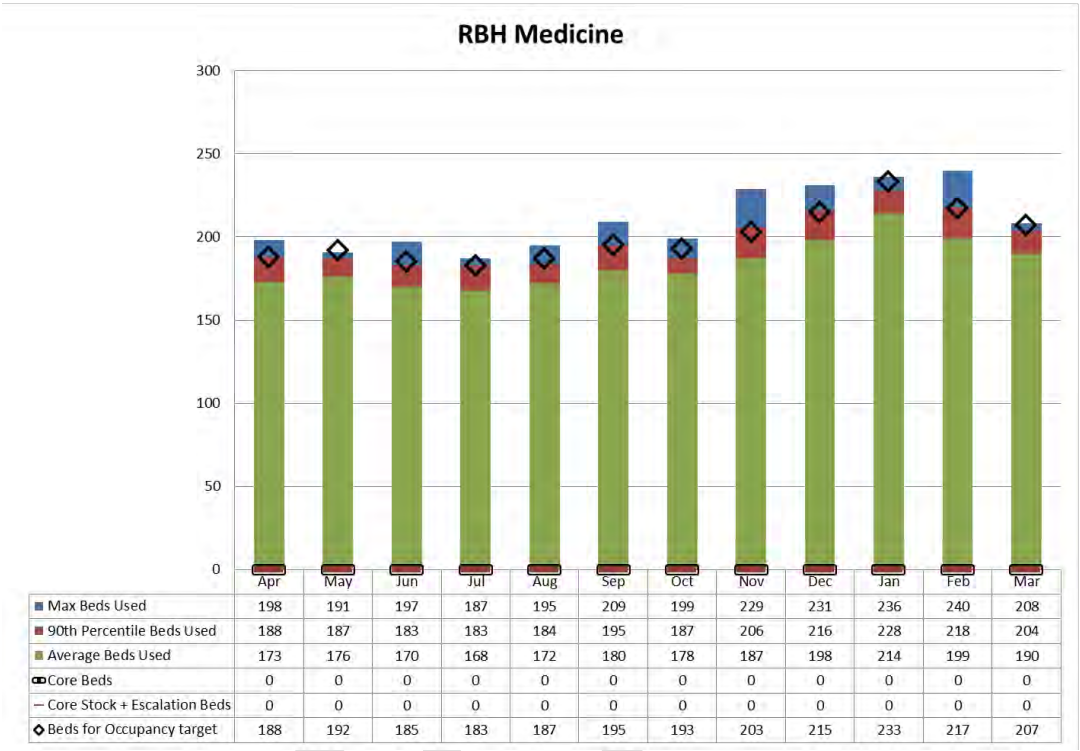
Medical Specialties



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Max Beds Used	111	105	99	108	104	126	103	106	115	100	106	121
90th Percentile Beds Used	108	103	95	102	99	109	99	95	105	93	106	110
Average Beds Used	97	93	85	91	90	99	90	88	97	88	92	99
Core Beds	0	0	0	0	0	0	0	0	0	0	0	0
Core Stock + Escalation Beds	0	0	0	0	0	0	0	0	0	0	0	0
Beds for Occupancy target	106	101	93	99	98	108	98	95	105	96	100	108

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
Medicine PH Site		
Review Consultant cover evenings/weekends	In planning phase - tbc	Tbc
Increased evening SpR cover (joint with DME)	**ADMISSION AVOIDANCE**	October 2020
Increase TIU staffing at weekend	**ADMISSION AVOIDANCE & OPTIMISED LOS** Through increased weekend activity on TIU	Tbc
Increase PIC line training for TIU staff	**ADMISSION AVOIDANCE & OPTIMISED LOS** Increase access to PIC line service	Tbc
In partnership with primary care & Community Partner develop a hot clinic to support patients with respiratory / flu / of COVID like symptoms within the community	**ADMISSION PREVENTION** **In planning Phase**	Tbc
Increase nurse practitioner workforce cover in AMU	**ADMISSION AVOIDANCE & OPTIMISED LOS** Mitigation for vacant Acute Physician posts	October 2020
Emergency PH Site		
Provide sufficient isolation spaces within all areas of ED (resus, majors, paeds)	**AMBULANCE WAITS & ED CONGESTION** Additional isolation capacity to prevent congestion within the Emergency Department	

Establish SDEC area for surgical specialties	**ADMISSION AVOIDANCE & ED CONGESTION** Increased SDEC offer for surgical specialties	
Establish UTC over a 24 hour period7 days per week to support all walk in presentations who would otherwise attend the Emergency Department	**ED CONGESTION & ADMISSION AVOIDANCE**	

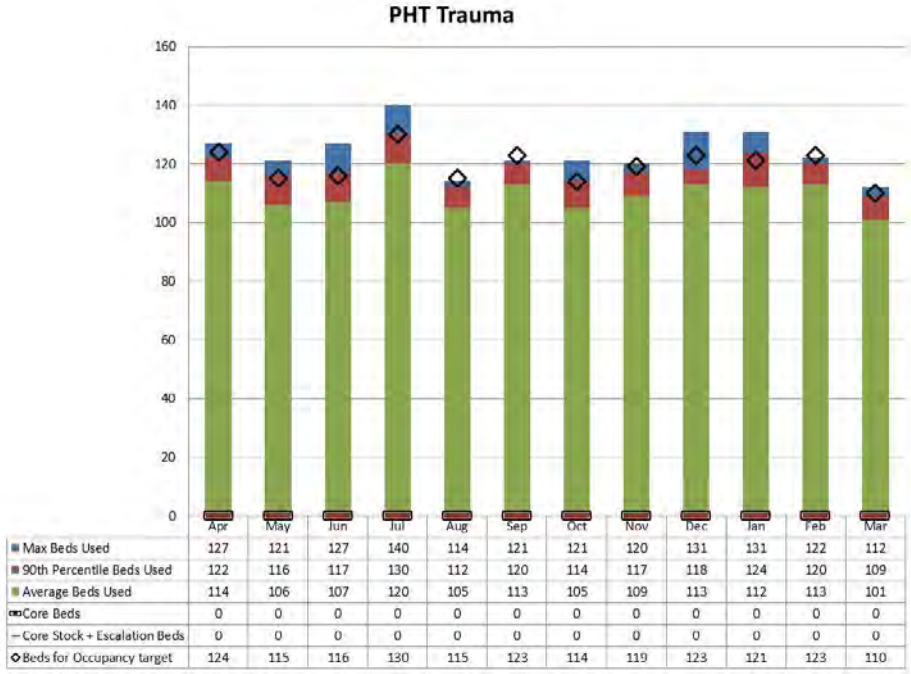


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Max Beds Used	198	191	197	187	195	209	199	229	231	236	240	208
90th Percentile Beds Used	188	187	183	183	184	195	187	206	216	228	218	204
Average Beds Used	173	176	170	168	172	180	178	187	198	214	199	190
Core Beds	0	0	0	0	0	0	0	0	0	0	0	0
Core Stock + Escalation Beds	0	0	0	0	0	0	0	0	0	0	0	0
Beds for Occupancy target	188	192	185	183	187	195	193	203	215	233	217	207

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
Medicine RBCH Site		
Additional consultant cover within the AMU across a 7 day period. 2 x Consultants to 2030 x 5 days and weekend cover from 1200 - 2030	**FRONT DOOR RESILIENCE** Additional senior decision making to help optimise LOS, admission avoid and support the emergency pathway.	October 2020
Increased use of Consultant connect to provide access to consultants for GPs.	**ADMISSION AVOIDANCE** Early and timely access to specialist advice will reduce referrals to hospital and reduce avoidable admissions.	Tbc
Establish an outlier team to provide dedicated support to patients residing outside of specialty.	**OPTIMISED LOS**	October 2020
Additional winter bed capacity providing up to 21 beds from 9 Nov increasing to up to a further 28 beds from the mid Dec	**BED CAPACITY**	October 2020
Specialties planning for 7 day cover with focus on weekend discharge	**FLOW** Increased number of weekend discharges will help to maintain flow out	Tbc

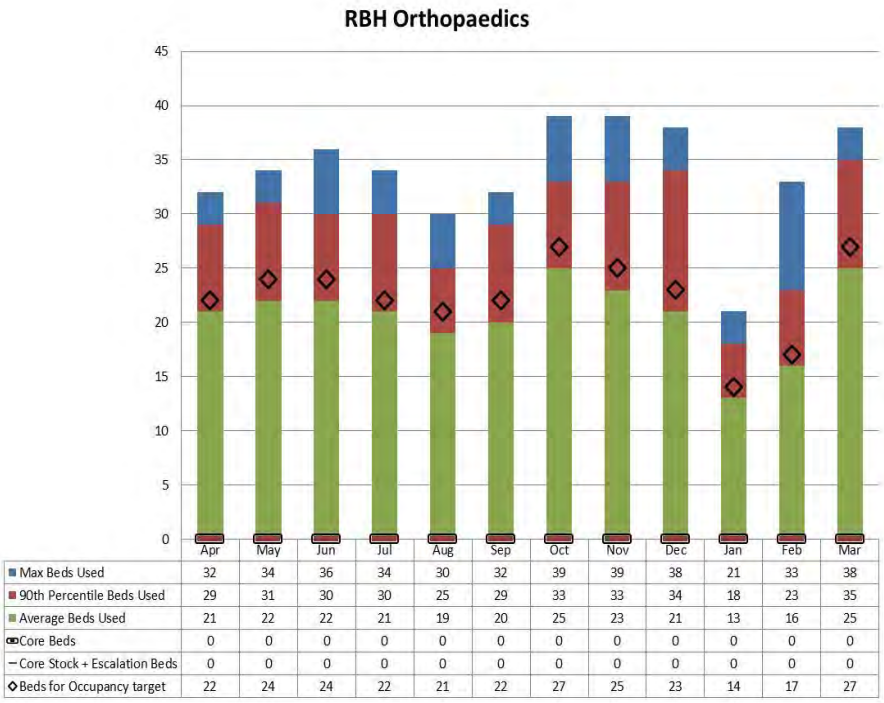
	of ED and assessment areas over a 7 day period.	
Standing up the Monday in-patient PCI list to support bed pressures.	**FLOW** Reducing elective services in a Monday to reduce bed pressures typically experienced immediately after weekend period.	December 2020

Trauma & Orthopaedic



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Max Beds Used	127	121	127	140	114	121	121	120	131	131	122	112
90th Percentile Beds Used	122	116	117	130	112	120	114	117	118	124	120	109
Average Beds Used	114	106	107	120	105	113	105	109	113	112	113	101
Core Beds	0	0	0	0	0	0	0	0	0	0	0	0
Core Stock + Escalation Beds	0	0	0	0	0	0	0	0	0	0	0	0
Beds for Occupancy target	124	115	116	130	115	123	114	119	123	121	123	110

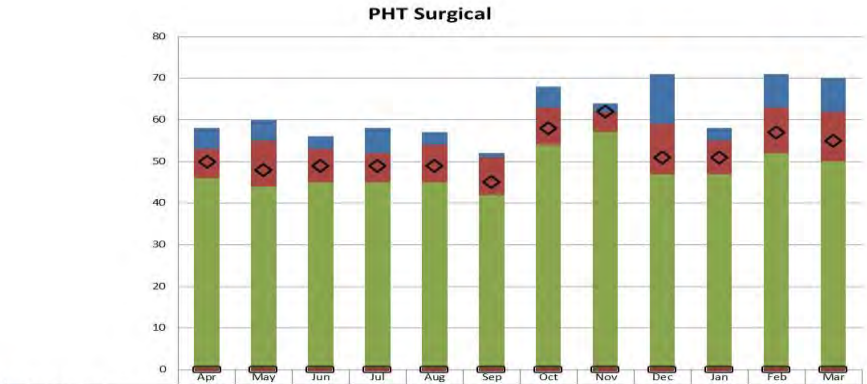
PLAN	BENEFIT / OUTCOME	GO LIVE DATE
T&O PH Site		
3 lists 7 days a week (Sat and Sun moving to mirror in week cover including ward rounds etc).	**OPTIMISED LOS** Increased access to theatres to support emergency patients, reducing pre-op length of stay optimising patient outcomes.	September 2020
Twice daily ward rounds will be in place to support flow throughout winter	**OPTIMISED LOS** Through increased access to senior review	October 2020
Establish a Trauma Assessment Area to expand SDEC offer to this patient group	**ADMISSION AVOIDANCE** **Preserving acute bed capacity through increased SDEC offer**	October 2020



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Max Beds Used	32	34	36	34	30	32	39	39	38	21	33	38
90th Percentile Beds Used	29	31	30	30	25	29	33	33	34	18	23	35
Average Beds Used	21	22	22	21	19	20	25	23	21	13	16	25
Core Beds	0	0	0	0	0	0	0	0	0	0	0	0
Core Stock + Escalation Beds	0	0	0	0	0	0	0	0	0	0	0	0
Beds for Occupancy target	22	24	24	22	21	22	27	25	23	14	17	27

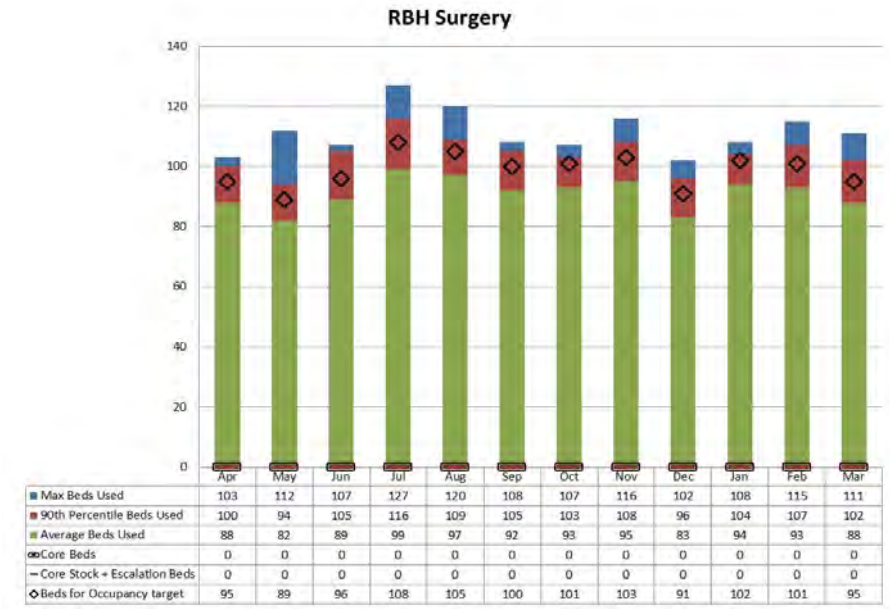
PLAN	BENEFIT / OUTCOME	GO LIVE DATE
Orthopaedic RBCH Site		
Plan to increase Geriatrician input for this patient group	**OPTIMISED LOS** In planning phase - tbc	Tbc
Orthopaedics to focus on utilisation and effective pathways to maximise use of Derwent.	**OPTIMISED LOS** **NOTE:** This will be critical as the Derwent will not be able to support additional winter capacity as planned to support Phase 3 recovery around elective activity	Ongoing
Cross site working to maximise use of bed base e.g post-op trauma		

Surgical Specialties



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Max Beds Used	58	60	56	58	57	52	68	64	71	58	71	70
90th Percentile Beds Used	53	55	53	52	54	51	63	62	59	55	63	62
Average Beds Used	46	44	45	45	45	42	54	57	47	47	52	50
Core Beds	0	0	0	0	0	0	0	0	0	0	0	0
Core Stock + Escalation Beds	0	0	0	0	0	0	0	0	0	0	0	0
Beds for Occupancy target	50	48	49	49	49	45	58	62	51	51	57	55

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
General Surgery PH Site		
Reviewing SDEC times to plan for expanded service	**ADMISSION PREVENTION:** Increased number of admissions prevented through increased use of ambulatory care.	Tbc
Establish a discharge area to support the timely access to beds needed to maintain flow.	**BED CAPACITY**	September 2020



PLAN	BENEFIT / OUTCOME	GO LIVE DATE
General Surgery RBCH Site		
Reviewing SDEC times to plan for expanded service	**ADMISSION PREVENTION:** Increased number of admissions prevented through increased use of ambulatory care.	Tbc
Review of bed phasing due to COVID in light of new IC guidance	**BED CAPACITY**	September 2020

Clinical Support Services

PLAN	BENEFIT / OUTCOME	GO LIVE DATE
Pharmacy RBH/PH		
During OPEL 4 escalation; Pharmacy Lead as single point of contact. MS Teams being set up.	OPTIMISED LOS Targeted prioritisation for preparation of discharge medication and summaries.	October 2020
Pharmacy Lead needs access to discharge tracker or regular updates to co-ordinate pharmacy workforce.	Effective deployment of staff towards admissions and discharges.	October 2020
Clinical pharmacy to be redeployed to admissions areas to	Minimise omission of critical medicines. Correct prescribing early in stay.	October 2020

review patients for medicines reconciliation and supply.		
Pharmacy Lead to work with senior pharmacy team co-ordinating service to meet demands with twice daily huddles		October 2020
Near patient dispensing with dedicated ward teams using mobile dispensing stations or pharmacy ward hubs.	Medicines labelled ready for discharge from early in stay, reduces time at discharge.	October 2020
If available, pharmacist/technician to support medicines reconciliation in ED as directed by Pharmacy Lead.	Minimise omission of critical medicines	October 2020
Senior Cancer Pharmacist or Pharmacy Lead to link daily with GM Cancer services to review capacity for chemo preparation.	Optimised throughput for Cancer beds.	October 2020
Radiology RBCH		
Respond to peaks in demand by flexing booking patterns for inpatients and outpatients. Backed up with additional evening or weekend WLI's to recover deferred outpatient activity.	Support early decision making to enable effective patient flow	October 2020
Radiology PH		
Maintain radiographer theatre availability for T& O	Reduce LOS	October 2020
Support Surgery in purchase of Mini II	Increase capacity for extremity surgery without requirement for radiographers	November 2020
Pathology RBCH		
Respond to peaks in demand by flexing phlebotomy provision where appropriate to ensure timely sample collection and ensure rapid result turnaround. Recruit additional phlebotomy staff on fixed term contract to support winter ward.	Support early decision making to enable effective patient flow	October 2020
Restart and scale-up respiratory (e.g. Flu etc.) and GI (e.g. Noro etc.) virus testing	Support early decision making to enable effective patient flow	October 2020
Continue to explore different methodologies to ensure appropriate and timely COVID-19 testing	Support early decision making to enable effective patient flow	October 2020

APPENDIX 2 - Bed Profile Poole Hospital Site

	ACTUAL BED SPACE		PRIORITY 1 - OPERATIONAL CAPACITY (FUNDED CAP less PHASING - BED LOSS Other)		PRIORITY 2 - UNPLANNED CAPACITY		PRIORITY 2 - PHASED BEDS		TOTAL BED SPACE (FULL ESCALATION)		OTHER (Difference between Actual Beds and Full escalation)
TOTAL G&A	**495**		**414**		**5**		**44**		**464**		**19**
MEDICINE											
AMU	30		30		0		0		30		
A4	28		18		0		5		23		5
A5	27		24		0		3		27		0
Portland	14		14		0		0		14		0
ACU	8		8		0		0		8		0
B5	6		6		0		0		6		0
TOTAL	**113**		**100**		**0**		**8**		**108**		**5**
ELDERLY MEDICINE											
RACE	24		21		0		3		22		
Kimmeridge	34		34		0		0		34		0
Lytchett	26		24		0		2		26		0
Lulworth	27		25		0		2		27		0
J4 Brownsea	26		22		4				22		
Lilliput	14				0		1		22		0
K4 SCU Rehab	19		19		0		0		19		0
TOTAL	**170**		**145**		**4**		**8**		**172**		**0**
SURGERY											
B4	30		22		0		8		30		0
C4E	14		14		0		0		14		0
C4 (SAU)	15		14		1		0		15		0
TOTAL	**59**		**50**		**1**		**8**		**59**		**0**
TRAUMA											
B2	28		10		0		4		10		14
E3	24		23		0		1		24		0
B3	30		22		0		8		30		0
C3	19		19		0		0		19		0
C2	12	12	12		0		0		12		0
TOTAL	**113**		**86**		**0**		**13**		**95**		**14**
ONCOLOGY											
J2 Durlston	17		17		0		0		17		0
J2 Sandbanks	23	start of 20	16		0		7		13		
TOTAL	**40**		**33**		**0**		**7**		**30**		**0**

APPENDIX 3: Bed Profile Royal Bournemouth Site

Excluded	Total	Closed to Social Distancing	other	Revised		Included	Total	Closed to Social Distancing	Other
ITU/HDU	14			14	Medical	AMU	36	16	
Ward 23 - CCU	15	4		11	Medical	Stroke	36	0	
Ward 14 (decant/winter ward - currently empty)	28			28	Medical	Ward 1	22	0	
Childrens Bay (Eye Unit - currently for day case/Ophthal paeds)				0	Medical	Ward 2	26	0	
Ward 9 escalation bay (now opened)	5		1	4	Medical	Ward 3	28	0	
Macmillan Unit	16			16	Medical	Ward 4	28	0	
eye unit	10		3	7	Medical	Ward 5	28		
ward 21 - will provide escalation 19 from november 20				0	Medical	Ward 22	28		
??Ward 8 - awaiting confirmation of funding (26)				0	Medical	Ward 24	25		
BPC - Private patient unit 7 beds) escalation (super green)				0	Medical	Ward 25	25		
				0	Medical	Ward 26	19	6	
				0	Medical	Ward 9	23		
				0	Surg/Ortho/med	Ward 7 L&R	21		
				0	Surg/Ortho	Ward 12	22		
				0	Enhanced Surgic	Ward 15 / 16	50		4
				0					
				0	Surg/Ortho	Ward 17	21		
				0	Surg/Ortho	Ward 18	15	5	
				0	Surg/Ortho	Derwent	29		
				0	Surg/Ortho	Ophthalmology			
				0	Haem	Ward 11	15		
Total	**88**	**4**	**4**	**80**		**Total**	**497**	**27**	**4**

UEC Structure

Opening Hours:	In hours: 08.00 – 18.00 On-call: 18.00 – 08.00
Contact Email:	nhsi.swuecoperations@nhs.net
Contact Number:	07743 600663
Cell Reporting Structure:	The UEC Cell will feed into the Regional Operational

Cell Leadership

Senior Responsible Officer:	Martin Wilkinson
Deputy Senior Responsible Officer:	Iain Wallen
Daily Cell oversight and Escalation:	Kevin Johnson

Cell Membership:

UEC Cell Operational lead:	Leighton Day
UEC Cell Ops Manager:	TBC
UEC Cell On-Call:	Kevin Johnson Rebecca Drew Siobhan Kelly Leighton Day
UEC Clinical Lead:	Dr Amelia Randle

Key points of contact

SW Urgent & Emergency Care Operational Team

On-call Manager mobile	nhsi.swuecoperations@nhs.net	07743 600663
UEC Operations & Improvement Lead	Leighton Day (*from 2nd Nov)* leighton.day3@nhs.net	**tbc**
SW UEC Programme Co-ordinator	Gail Jacomb gail.jacomb@nhs.net	07710 152917
SW UEC Business Support Assistant	Vickie Lewis vickie.lewis@nhs.net	07825 341584

Systems - Senior Relationship Manager

BNSSG	Julie Smee	jsmee@nhs.net
BSW	Scott Riley	scott.riley@nhs.net
Gloucester	Karen Burton	karen.burton5@nhs.net
Somerset	Sharon Wilson	sharon.wilson15@nhs.net
Cornwall & Devon	Will Doran	will.doran@nhs.net
Dorset	Sharon Wilson	sharon.wilson15@nhs.net

Our Purpose

To provide support for daily UEC operational performance across the South West Region systems.

- To review & evaluate daily data and reports regarding Urgent and Emergency Care performance.
- Identify areas of concern and where necessary ensure appropriate additional reports are submitted (where triggers are not met).
- Communicate with Systems to understand the actions being taken to resolve the identified concerns.
- Daily communications with exceptions by 11am
- Daily call with ROC and system from **11am (please see below)**
- Ensure information is received from systems in a timely manner in line with National & Regional Key Lines of Enquiry (KLOE).
- To give confidence of forward planning for winter periods and to fully understand System & Trust positions, enabling proactive action planning and outcomes.
- Guide and advise in the set-up of optimum Winter Rooms;
    - how to do this well,
    - share ideas,
    - processes,
    - governance
    - leadership within Trusts

Our commitment

- To review data and provide support for Systems/Trusts in a timely manner each day.
- To assist assurance measures regarding improvement actions being taken.
- A senior Regional Lead will be available each day for the duration of the winter period.
- A daily oversight structure will enable critical performance issues to be identified, isolated, and mitigated as quickly as possible.
- The ROC will provide a written brief (if required) for national colleagues to give an overview of regional performance and any specific challenges being experienced. A daily escalation call with national colleagues will take place, when required, by exception.
- Provide short notice briefings as and when required.

Winter Room will go Live on the 2nd November 2020.

Our expectations

- Trigger reports to be submtted by Systems to the RegionaL Operation Centre (ROC) by 10 a.m. the following day.
- The ROC/UEC will review all system data by 10.45am. There will be no expectation for additonal written summaries to be submitted.
- Each STP Winter Room Lead will be invited to a ten minute Reginal Daily Winter call, that will include SWAST. This will be led and ccorndinated by the Reginal Operation Centre (via MS Teams).
- We expect a daily narrative to include all exceptions that may be affecting overall system performance. This will include:
    - What is the current in day picture?
    - Where are the key risks?
    - What are the actions?
    - What additional support do you need form the Region?

We suggest that this will include softer data and local intellinegence, to undertsand a realisitc system position.

Trigger Reporting; to be submitted each applicable day by 10 a.m.

- OPEL 4 system level
- OPEL 4 Trust level
- System failure – critical incident
- Sub 80% all type performance
- Drop in performance of 10% or more, from previous day
- All 12 hour delays
- All handover delays of 60 mins or more
- All handover delays of 30 mins > 10
- Significant IPC (Flu) issues – more than 10% of bed stock
- G&A Bed occupancy over 85%

DAILY System Action (*expected 7 days per week*)	**System Calls with ROC & SWAST via MS Teams**		**ROC Action**
Exception reporting to ROC daily england.sw-incident1@nhs.net	11.00 – 11.10 a.m.	BNSSG	Review narrative and report to Regional SW UEC teams and National teams accordingly. Highlight any issues by 12.15 p.m.
	11.10 – 11.20 a..m.	BSW	
	11.20 – 11.30 a.m.	Cornwall	
	11.30 – 11.40 a.m.	Devon	
	11.40 – 11.50 a.m.	Dorset	
	11.50 – 12 noon	Gloucester	
	12.00 – 12.10 p.m.	Somerset	

APPENDIX 5 – Key Lines of Enquiry for Winter Assurance Framework

Workstream area	Domain	KLOEs
Acute care	Demand	In what ways are systems working to reduce avoidable admission into hospital or other environments?
Acute care	Demand	What are the key drivers of system demand and how well are these understood?
Acute care	Demand	How will systems maintain effective oversight of performance across the winter months?
Acute care	Demand	How are systems seeking to balance increasing emergency demand with existing elective programmes?
Acute care	Demand	Have CCGs and providers undertaken cross-border planning conversation to agree onwards care (repatriation) Standard Operating Procedures?
Acute care	Capacity and Resources	How are systems seeking to make maximum use of existing and potential capacity this winter?
Acute care	People and workforce	What steps are systems taking to maximise the utilisation and effectiveness of their permanent workforce?
Acute care	People and workforce	Where workforce gaps exist what potential contingency procedures can be invoked?
Acute care	People and workforce	What is the current system fill-rate and what steps are being taken to improve this if necessary?
Acute care	Exit Flow	What mechanisms are in place for systems to understand and minimise high impact users?
Acute care	Exit Flow	How are systems seeking to work together to support improved flow at system exit points?
Acute care	External events	What system impacts are anticipated related to extreme weather?
Acute care	External events	What system impacts are anticipated related to flu?
Acute care	External events	How are systems working with their Covid-19 teams to understand anticipated impacts related to a second wave of Covid-19?

University Hospitals Dorset
NHS Foundation Trust

Covid-19

2nd Wave Plan

November 2020

Content

- Principles
- Incident Management
- Covid-19 Daily Trust & System Dashboards & Incidence Update
- Infection Prevention & Control
- Escalation Plans:
  - Front door
  - Bed capacity
  - Critical Care
  - Elective care
  - Discharge
  - Workforce
- Personal Protective Equipment Update
- Pharmacy update
- Staff Wellbeing /Our People
- Current Risks & Other Issues

These slides should be considered in conjunction with: the Trust's Phase 3 plans, Winter Plan and Leadership Forum Learning from Covid

Context and Guiding Principles – Amanda Pritchard

“Though the infection rate and local circumstances will continue to vary across the country, we know the guiding principle of our plans will be the same; to enable the NHS to manage COVID-19 demand in the event of a second peak, while also safely maintaining as much of our non-COVID activity and services as possible.

To do this, supporting our people will be critical and supporting each other through the coming months will matter just as much. Please continue to use networks, resources and experience across ICS/STPs and regions, to support your response to increased demand over winter”.

Covid-19 - 2nd Wave Principles

- The Trust's Covid-19 2nd Wave plan should be seen as an integral part of/interlinked with our Winter and EU Transition Plans
- Plans based on previous experience, current national and local incidence/R number, with ability to escalate as required
- All departments reviewing Business Continuity Plans
- Expectation that Dorset system Silver approach in place, including oversight of mutual aid and support through key programmes e.g. Home First
- Anticipate higher levels of non Covid urgent care demand than 1st Wave, with greater occupancy – need to maintain non Covid pathways (*phased de-escalation to clinically urgent/prioritised based on triggers*)
- Phased approach to escalation and standing down services/reallocating staff / 'major incident' approach last resort
- Escalation plans based on key triggers, e.g. local incidence, levels of presentation/admission of Covid patients, bed occupancy and demand – *see Escalation Process document for bed capacity*
- Tactical Incident Management approach in place, commenced 3x weekly, currently escalated to daily Tactical/Strategic Command as incident and system escalation dictates
- Daily monitoring supported by site, UHD with system dashboards tracking data and trends
- In line with national IPC guidance on Low, Medium and High risk pathways
- In line with national IPC guidance on PPE (inc face coverings), distancing, visitor guidance

Covid-19 - 2nd Wave Principles cont.

- Swabbing/testing is based on portfolio of platforms to maintain resilience, **noting fast turnaround testing capacity remains a significant challenge** and awaiting confirmed delivery of additional Samba Units .
- Swabbing/testing moving closer to clinical pathways where environment allows (capital works in progress) and staff recruitment is underway
- Approach to Supplies and Medicines as per 1st Wave
- Separation of Low, Medium, High risk pathways, noting transitional phases
- Maintenance of separate Medium/High risk pathways in Emergency Departments with escalation to separate areas and high/medium risk Resus
- Maintain blended speciality admission units, with separate Low, Medium, High risk pathways, until trigger to separate High – Low Risk units – noting increased incidence and asymptomatic presentations suggest medium/high risk speciality admission units may offer better clinical outcomes
- Maintain speciality pathways until 'trigger' to mixed speciality, *noting separate surgery/medicine*
- Maintain acute specialist pathways (e.g. acute GI, Cardio) using side rooms/cohorting
- Escalation plan from side room, to bay cohort, to identified High/Medium risk ward/s (*moving to East Wing at RBCH*)
- Critical Care escalation plan agreed across both sites plus local (mutual aid) Network

Covid-19 - 2nd Wave Principles cont.

- Preserve outpatient and elective capacity wherever possible to support Phase 3 recovery plan (*eg. Derwent and RBCH - W12 'super green'*) - phased de-escalation of elective capacity based on triggers – **noting as at 11 Nov 20, 'firebreak' approach with elective cancellations pending D2A delivery and next phase winter beds (Dec) being considered**
- Patients to attend hospital only when really necessary (tele-med/videoconferencing)
- Workforce planning based on the following (*note, funding requested through Mth 7-12 business case prioritisation process*)
  - Planning / recruitment for additional bed and critical care capacity (nursing, medical, other)
  - Phased re-allocation of staff (e.g. mixed medical teams) subject to triggers based on Covid, skill mix requirements, expansion
  - Nursing escalation plan
  - Preserve training and education as far as possible
- Well established HR guidance, including for staff testing and isolation, available via Trust intranet and remains under review if/as further national guidance is released
- Staff risk assessments undertaken and remain under regular review, especially for vulnerable/higher risk staff
- Recognition of the impact on our staff – well established wellbeing support continues
- Covid 2nd wave plan implemented alongside winter plan, which includes flu campaign, EU Exit planning and Discharge to Assess
- Support national and system protocols that maintain safety in Care Homes

Tactical Group

University Hospitals Dorset
NHS Foundation Trust

In line with phase 3 reset letter and during periods when managing COVID-19, the Tactical Group will take on the role of the Incident Coordination Centre in managing operational services across all sites:

Role of Tactical Group

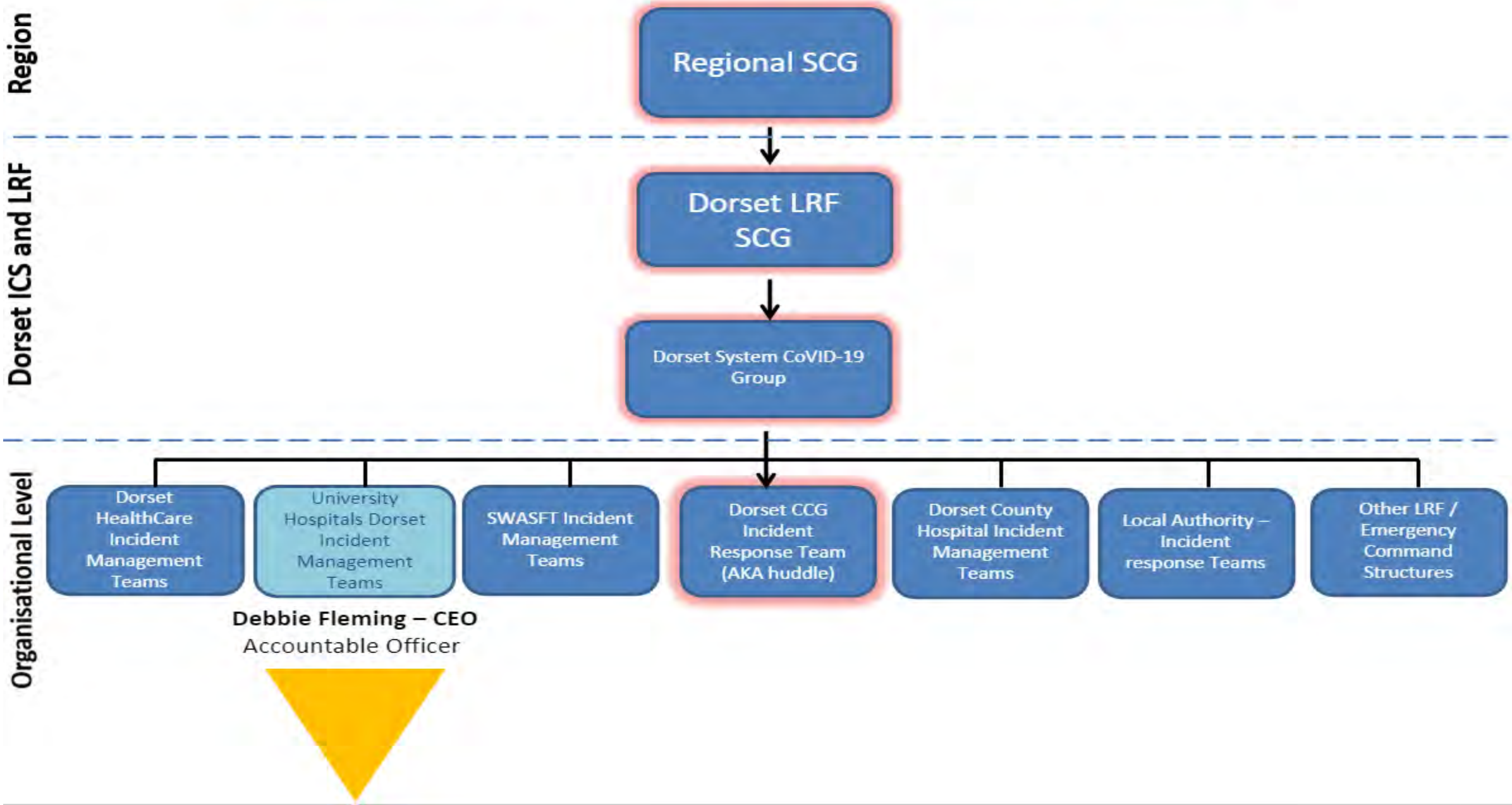
- To coordinate and orchestrate all plans to manage all services during the COVID-19 pandemic
- To receive information and escalation reports from Operational Cells, Tactical will review and take decisive action as required within its remit
- To receive information and escalation reports on operational patient flow, to review and agree flow plans to ensure they are operationally and COVID-19 safe
- To share COVID-19 related matters and maintain communication with Care Groups and Corporate Services when required
- To manage the COVID-19 major.incident mailbox and all related communications
- To support the implementation of changing national and clinical guidance in relation to COVID-19
- To act as a conduit for communication between local and system meetings in response to managing services during the COVID-19 pandemic
- **To escalate any COVID-19 related key issues or risks or items for decision to Strategic Commanders using the escalation briefing form when required**

In the absence of a surge, the Tactical group will meet informally as above, this forum will help Tactical Commanders develop cross site relationships helping us work together in the event of a Major Incident

National COVID-19 Command Structure for reference & context

Health Command & Control

Dorset COVID-19 Command Structure for reference & context



University Hospitals Dorset
NHS Foundation Trust

Strategic Group

Accountable Officer
Debbie Fleming
Chief Executive Officer

Strategic Commanders will represent the Trust at Dorset System Silver meetings

Nurse Commander
Paula Shobbrook
Chief Nursing Officer

Medical Commander
Alyson O'Donnell
Chief Medical Officer

Incident Commander
Mark Mould
Chief Operating Officer

Emergency Planning Officer
Libby Beesley
Interim Lead Emergency Preparedness & Resilience Officer

Communications Commander
Jamie Donald / Richard Moremon
Head of Communications

Human Resources Commander
Karen Allman
Chief People Officer

Tactical Commanders
Donna Parker
Deputy COO

Jacqueline Coles
Deputy COO

Note Strategic Group will stand up in the event of a surge

Tactical Group

University Hospitals Dorset NHS Foundation Trust

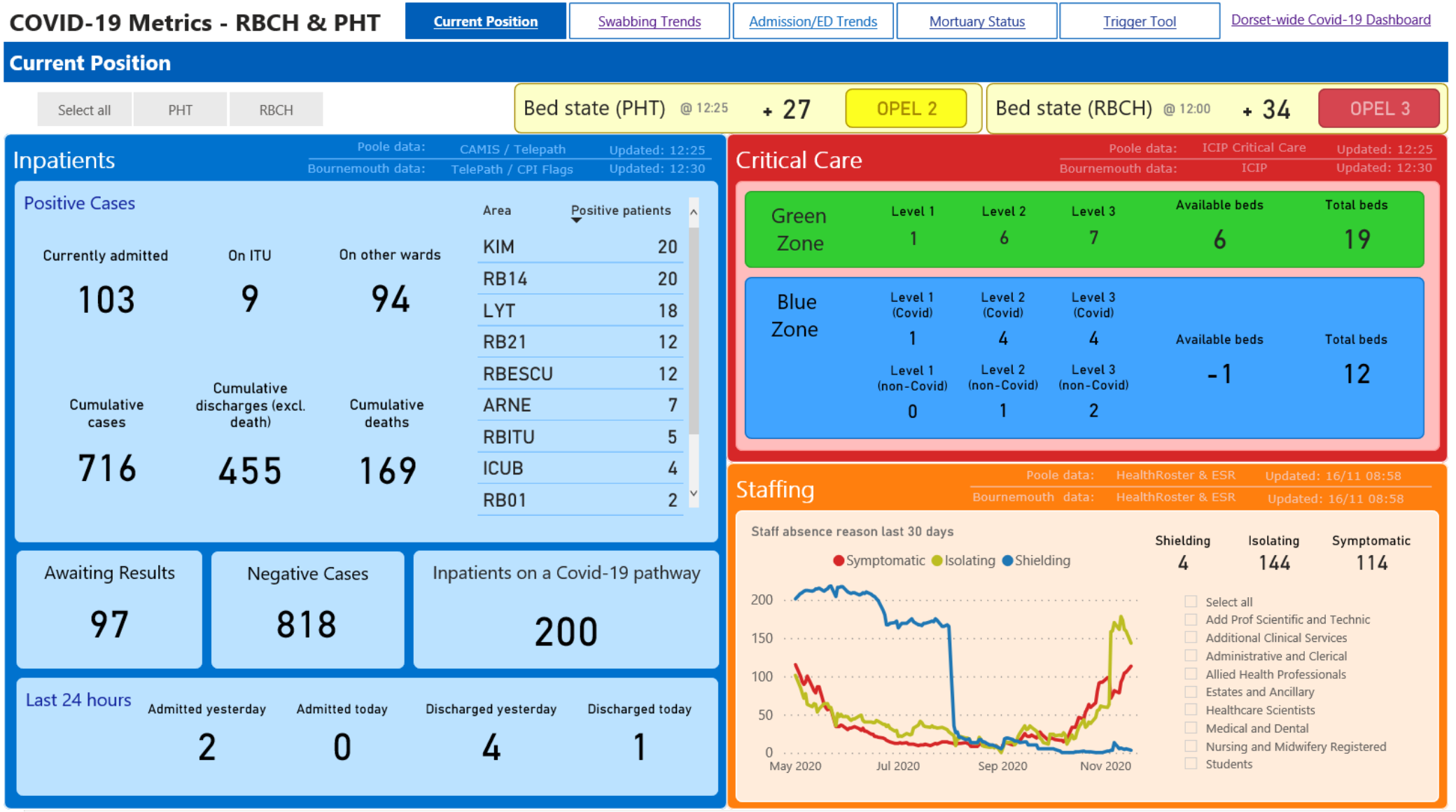
Incident Commander
Mark Mould

Note Tactical Group will stand up formally in the event of a surge as directed by Strategic

Tactical Nurse Commanders	Tactical Medical Commanders	Tactical Incident Commanders	Emergency Planning	Communications	Human Resources
Deputy Chief Nurses	**Deputy Chief Medical Officers**	**Deputy Chief Operating Officers**			**Deputy Chief People Officers**
Group Directors of Nursing	**Care Group Medical Directors**	**Group Directors of Operations**			
Interim Heads of Nursing	**Medical Director – S&T**	**Deputy Group Directors of Operations**			
	Clinical Directors*	**Associate Directors***			

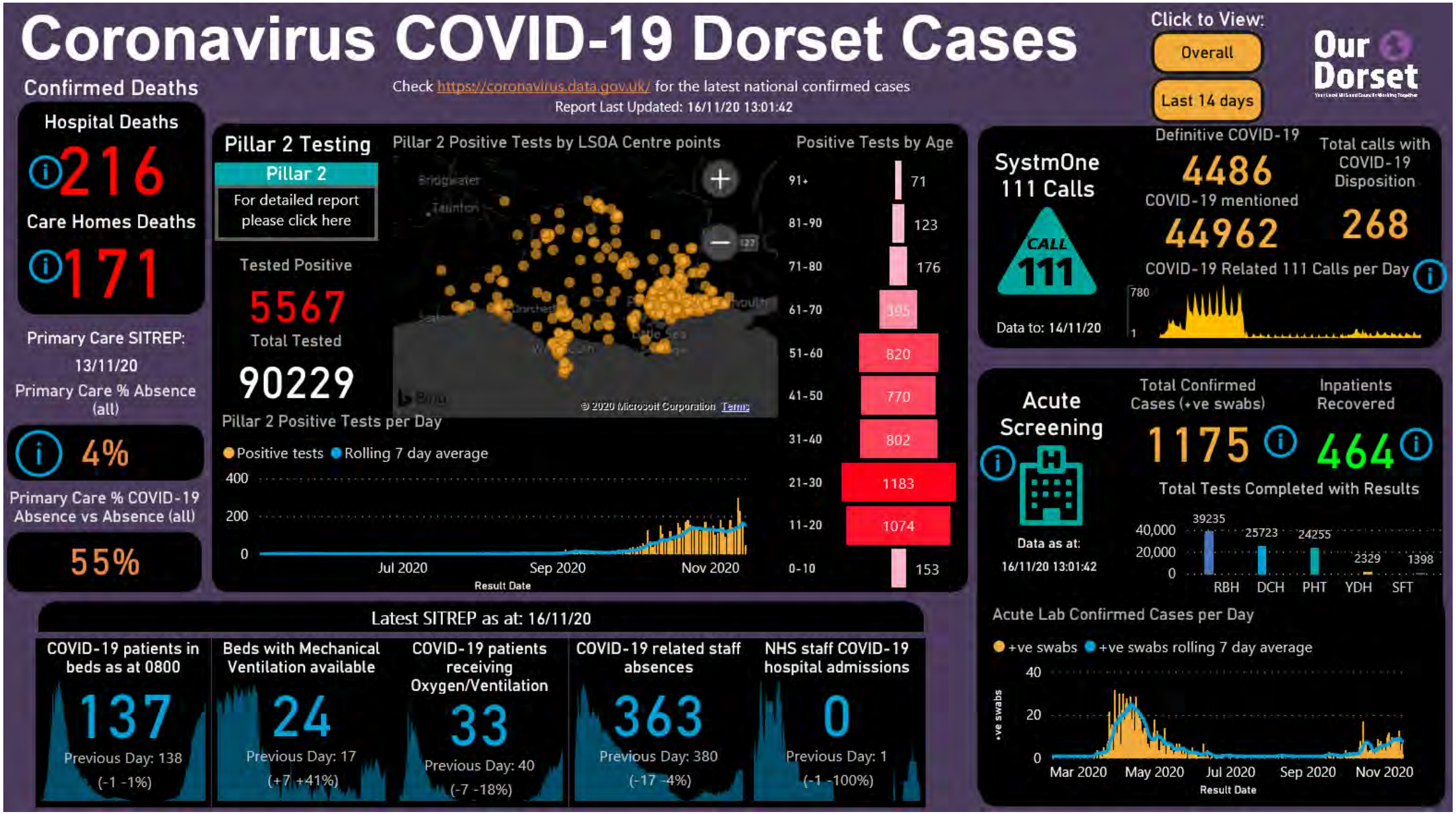
Covid-19 Daily Trust Dashboards

Joint: Poole Hospital and RBCH Sites



Note: Covid dashboard currently overstates RBCH bed state due to including some beds currently only staffed for day case.

Covid-19 Dorset System Dashboard



Note:

Excellence in Infection, Prevention and Control (IPC)

- Testing continues:
    - Emergency patients tested on admission with a further retest 5-7 days after admission
    - Patients returning to nursing/care homes tested 48 hrs prior to leaving hospital
    - Elective patients tested 72 hrs prior to surgery (isolation as per national guidance)
    - Routine staff screening (commenced with haematology and oncology staff across UHD + staff on SIREN study)
    - Symptomatic staff and their symptomatic households
    - Antibody tests completed for >90% of staff, continuing for remaining staff
- Maintain pathways that protect patients who are clinically extremely vulnerable (e.g. previously 'shielded')
- Guidance implemented for the wearing of surgical masks/face coverings for all staff, visitors and patients
- Visiting guidance updated
- Social distancing to be observed – signage in our hospitals in public areas 'Hospital Highway Code'
- Toolkit developed to support safe working (Mask wearing/ risk assessments for non-clinical areas etc)
- Daily IPC Team led risk assessment to ensure bed numbers, current low-med-high risk pathways, cohorting and practices support good infection control
- Matrons IPC audit for assessment of on-going clinical practice compliance
- Reviewed cleaning requirements across the Trusts (*note, business case submitted to Mth 7-12 prioritisation process*)
- Focus on nosocomial infection – robust review process for all potential hospital acquired infections
- NHSI IPC Board Assurance Framework self assessment completed and presented at Joint Quality Committee / Healthcare Assurance Committee

Escalation Plans – 'Front Door'

Emergency Departments and UTCs

- Capacity increased across both sites*
- Improved and separated (Minors/UTC and Majors) waiting areas being implemented (capital bids) and distancing/IPC practices in place with 'streaming'
- Minors/UTCs separate to main departments* (Majors) – distancing and IPC practices in place
- Separate and additional Majors areas* and cubicles which support medium/high risk pathways
- Ability to escalate to separate high/medium risk Resus (RBH site: use F2S area; Poole Site: using 2 existing separate resus areas)
- Escalation plans in place to manage ambulance queuing: Poole: space for up to 5 ambulance trolleys staffed by ambulance; RBCH: 4 ambulances queuing with social distancing, capital build to deliver extended capacity below . Improvement action plan also underway.
- 111 First Service *NOTE: delay in 'go live,' currently being worked through.*

Capacity	Minors/ UTC	Majors (high risk)	Majors (med risk)	Resus (high risk)	Resus (med risk)	Other
Poole Hospital Site	9 rooms	11	14	3	2	3 paeds
RBH Site	8 cubicles, 6 rooms	14	16 (12 when Resus escalated)	3	2 when escalated	

**Note, ED staffing templates to support separated areas being considered against M7-12 business case prioritisation*

Escalation Plans – Bed Capacity

The following tables provide a summary of capacity vs demand and the bed deficit

		Oct	Nov	Dec	Jan	Feb	Mar
A: CAPACITY	Forecast Core Capacity	923	919	929	955	955	955
B: DEMAND (History repeating)	Baseline Average Bed Demand based on that observed in 2019/20	968	990	989	1037	1016	1003
Baseline Scenario	Beds required to remain in within 92% occupancy with 0% growth in B	1051	1077	1076	1126	1102	1088
	Additional Bed Requirement to A	128	158	147	171	147	133
1	Beds needed to remain within 92% occupancy & 100% efficiency gain through D2A model; 0% growth	991	987	992	1028	1008	979
	Additional Bed Requirement to A	68	68	63	73	53	24
2	Beds needed to remain within 92% occupancy & 50% efficiency gain through D2A model; 0% growth	1021	1032	1034	1078	1055	1033
	Additional Bed Requirement to A	98	113	105	123	100	78
3	Beds needed to remain within 92% occupancy & 50% efficiency gain through D2A model 3.5% growth in non elective activity	1053	1069	1070	1117	1093	1072
	Additional Bed Requirement to A	130	150	141	162	138	117
4	Beds needed to remain within 92% occupancy & phased efficiency gain over 6 month period, through D2A model; 1% growth	1029	1032	1026	1068	1038	1033
	Additional Bed Requirement to A	106	113	97	113	83	78
Other Considerations							
SDEC	SDEC Efficiency gains	-20	-20	-20	-20	-20	-20
Unplanned Winter Capacity	Ward 21 & C4 SAU		-20	-20	-20	-20	-20

SITE	OCT	NOV	DEC	JAN	FEB	MAR
RBCH	41	38	19	34	14	19
PHF	45	36	39	39	29	19
TOTAL	**86**	**74**	**58**	**73**	**43**	**38**

Bed Modelling - Worked through 4 scenarios across both sites

Forecast Core Capacity

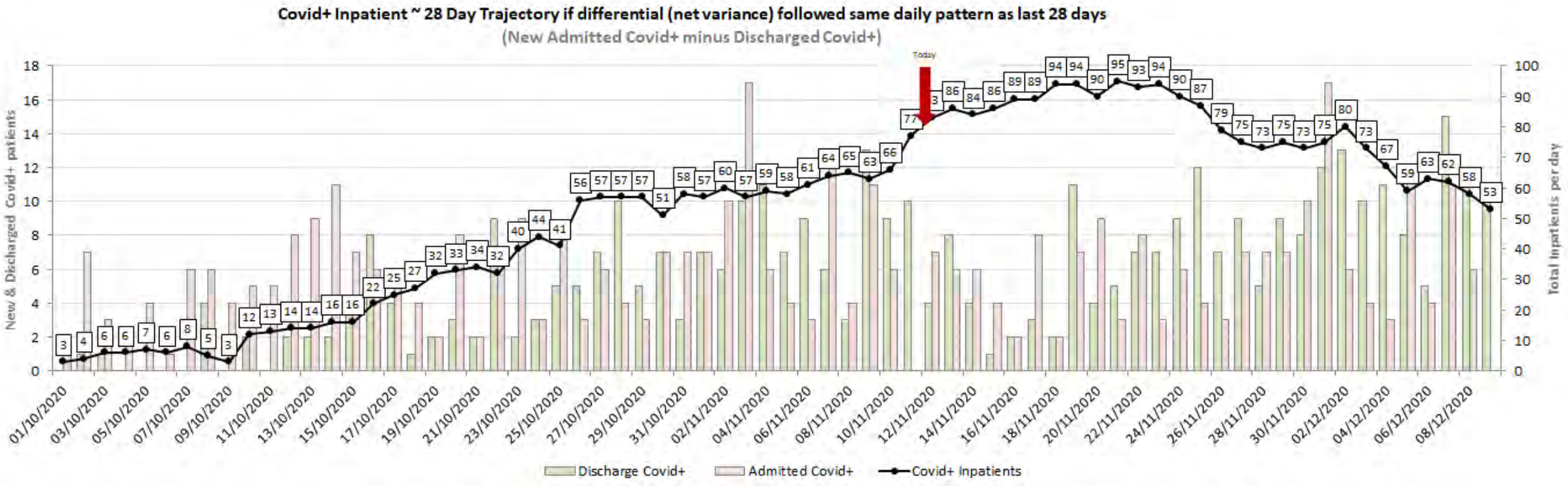
1. 92% Occupancy 0% Growth
2. 92% Occupancy, 100% delivery of Home first 0% Growth
3. 92% occupancy 50% delivery Home first , 3.5% growth in non-elective
4. **92% occupancy Phased efficiency of home first, 1% growth in non – elective activity**

Bed Surge Plan

PHASE	MONTH	PLAN	OPEL	RESPONSE
1	Sep-20	D2A Implementation Internal support to D2A to fully optimise length of stay for patients: Golden discharges; Criteria to Reside; Effective twice daily ward rounds Daily consultant reviews.	OPEL 1	All core services delivered; Good access to specialty beds; Access to blue and green pathways; Critical Care @ Surge level 1; Occupancy < 85%.
2	Oct-20	Planned additional winter capacity Winter schemes D2A model changes	OPEL 2	Twice daily review of all TCIs via Ops Meetings; Twice daily review of critical care capacity; Twice daily review of all specialist beds to ensure access; Twice daily review of ADDs vs predictors; Specialty planning to ensure flow and access to specialty beds.
3	Nov-20	Additional winter capacity (Surge / Flex Capacity) Winter schemes	OPEL 3	Stand down planned electives - 1) P4, Orhtopardic and Day Cases - 2) P3s Cancellations Joint planning with System to: - ensure alignment in standing down elective activity - explore areas of mutual aid - planning across sites / mutual support
3	Dec-20	Planned additional bed capacity	OPEL 4	Pre-alerting CCG & region and agree Triggers met

- ***OPEL escalation process continues through all winter planning phases, responding with escalation actions as per OPEL plan as/when required.***
- ***Note: As at 16 Nov 20 – OPEL 3 action options being worked up/reviewed.***

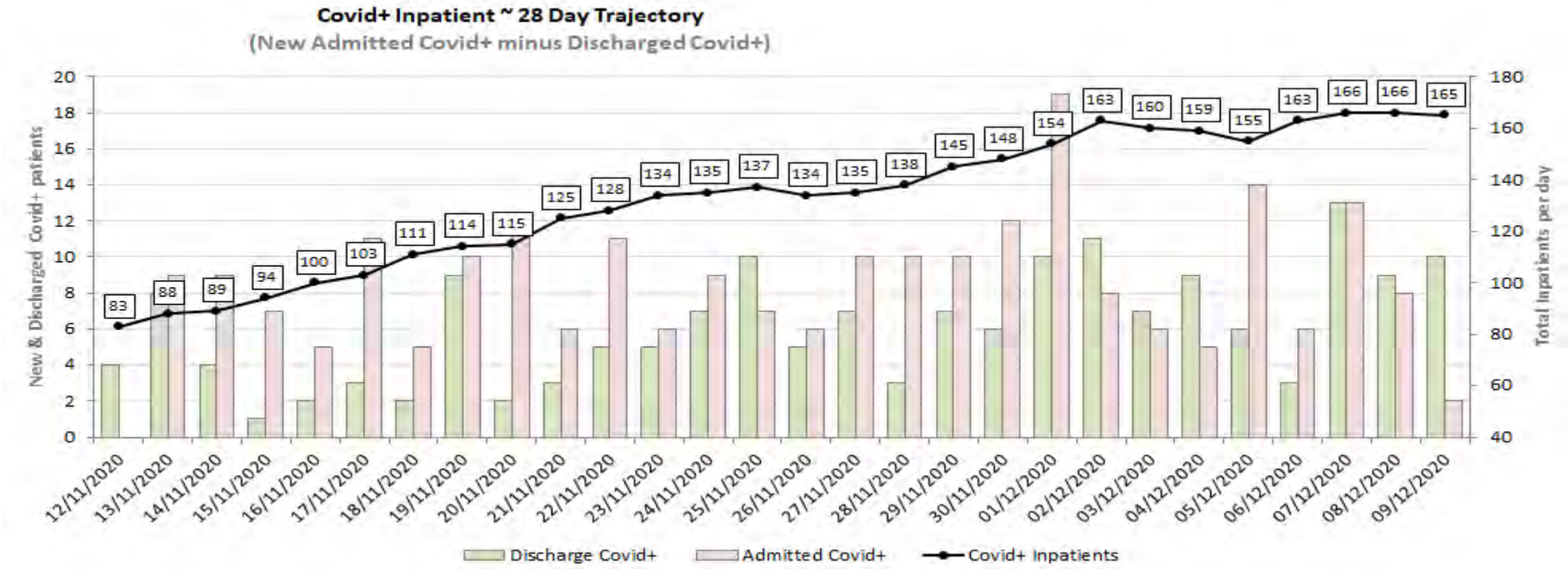
COVID Scenarios



The 'best case,' scenario is laid out above. Planning assumptions are

- Rate of admission mirrors Dorset infection rate modelling (note: level of confidence decreases beyond 1-2 week period)
- Increased system wide bed capacity to be able to discharge COVID + patients;
- No further outbreaks or hospital acquired infection.

COVID Scenarios



The 'worst case,' scenario is laid out above. Planning assumptions are

- Rate of admission mirrors Dorset infection rate modelling (note: level of confidence decreases beyond 1-2 week period)
- No additional system wide bed capacity to facilitate discharges of COVID + patients;
- Additional COVID cases acquired within the hospital

Escalation Plans – Bed Capacity

Actions to mitigate risks inherent in assumptions:

- Senior led Home First Board – monitoring of programme delivery
- Internal Home First work streams – monitoring of delivery
- Implementation of QI LoS schemes and monitoring
- Escalation protocols (*noting OPEL 3-4 likely to necessitate consideration of complex risk; 95+% occupancy; reduced elective*)

Actions to mitigate remaining gap:

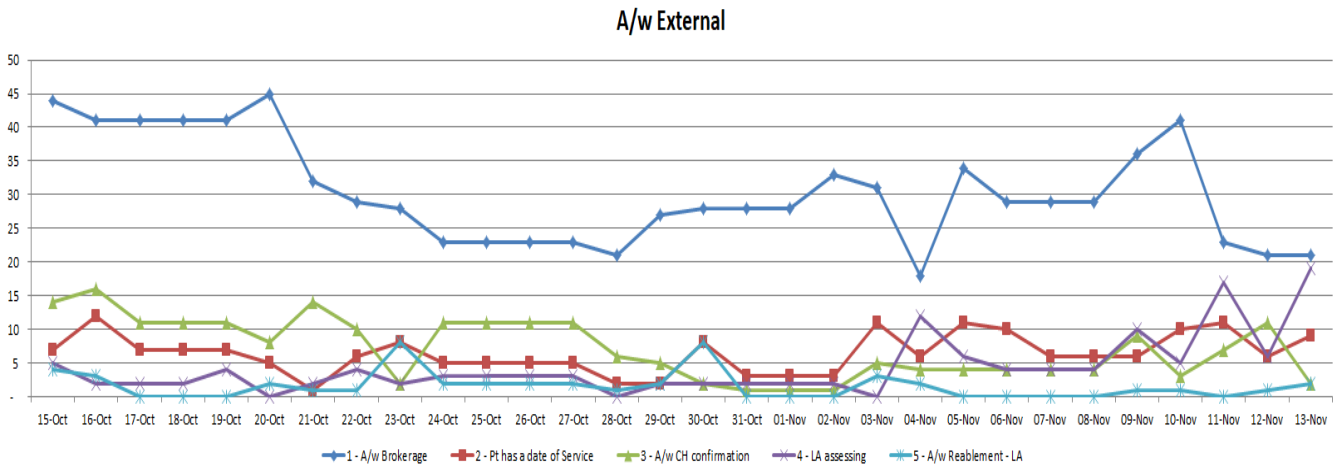
- System working to support admission avoidance, Home First and increased discharges
- Option appraisal for additional bed capacity e.g. Care Home beds/care packages, modular unit/site refurbs (*noting timescale and risk limitations on latter two*)
- Support delivery of further step up in Home First programme work streams
- Review further IS capacity to release surgical beds / MRFDs

Escalation Plans – Discharge & Home First

Maintaining system wide flow is critical in being able to ensure the continuation of quality care and delivery of key services. Occupancy driven by a high number of medically ready to leave numbers will impact on many aspects of acute care including ambulance handovers, flow, quality and potentially elective commitments.

ESCALATION

- Exec led 'Home First,' board in place
- Internal UHD reporting of medically ready to leave position;
- Number of 'medically ready to leave,' patients feeds into the system wide OPEL framework;
- Daily SITREP to Bronze and NHSe/I including number of medically ready to leave patients;
- 3 x weekly Bronze calls to manage escalation and agree mitigation (see system wide Health Command Structure)
- System silver team meets daily, acting as an escalation point;
- Senior Systems lead post agreed and is being recruited to. This role will provide oversight of t
- System wide integration dashboard in process of being developed which will provide complete visibility of how effectively the discharge model is performing and system wide flow;



Provider-Level Healthcare Escalation Triggers (not finalised)

Escalation Triggers		A&E Performance	Number of Ambulance Handover Delays Over 15 mins	G&A Bed Occupancy	Beds Closed Due to IPC	Criteria To Reside Not Met %age of G&A	Staffing
OPEL 1	DCH	>95%	0	<75%	<2%	<1%	<2%
	UHD P	200mins	0	<75%	<2%	<1%	<2%
	UHD B	>95%	0	<75%	<2%	<1%	<2%
	DHC	>95%	-	<75%	<2%	<1%	<2%
	SWAST	-	-	-	-	-	<2%
OPEL 2	DCH	85%- 94.9%	0	76%-85%	<2%	1-5%	<3%
	UHD P	210mins	0	76%-85%	<2%	1-5%	<3%
	UHD B	85%- 94.9%	0	76%-85%	<2%	1-5%	<3%
	DHC	85%- 94.9%	-	76%-85%	<2%	1-5%	<3%
	SWAST	-	-	-	-		<3%
OPEL 3	DCH	75% - 84.9%	0	86%-95%	<2%	5% - 10%	<4%
	UHD P	220mins	0	86%-95%	<2%	5% - 10%	<4%
	UHD B	75% - 84.9%	0	86%-95%	<2%	5% - 10%	<4%
	DHC	75% - 84.9%	-	86%-95%	<2%	5% - 10%	<4%
	SWAST	-	-	-	-	-	<4%
OPEL 4	DCH	<74.9%	0	>96%	<2%	>10%	>5%
	UHD P	230mins	0	>96%	<2%	>10%	>5%
	UHD B	<74.9%	0	>96%	<2%	>10%	>5%
	DHC	<74.9%	-	>96%	<2%	>10%	>5%
	SWAST	-	-	-	-	-	>5%

Assumptions made:

- Normal acute flow achieved at 85% capacity
- To achieve flow with Covid-19, flow must be in the region of 75%
- G&A Bed numbers are deemed as **operational viable capacity**

Acute Hospitals Daily

If on these triggers, it is forecasted that demand is over forecasted capacity, and the provider is considering the reviewing and evaluation of elective activity, then the provider declares **OPEL 3**.

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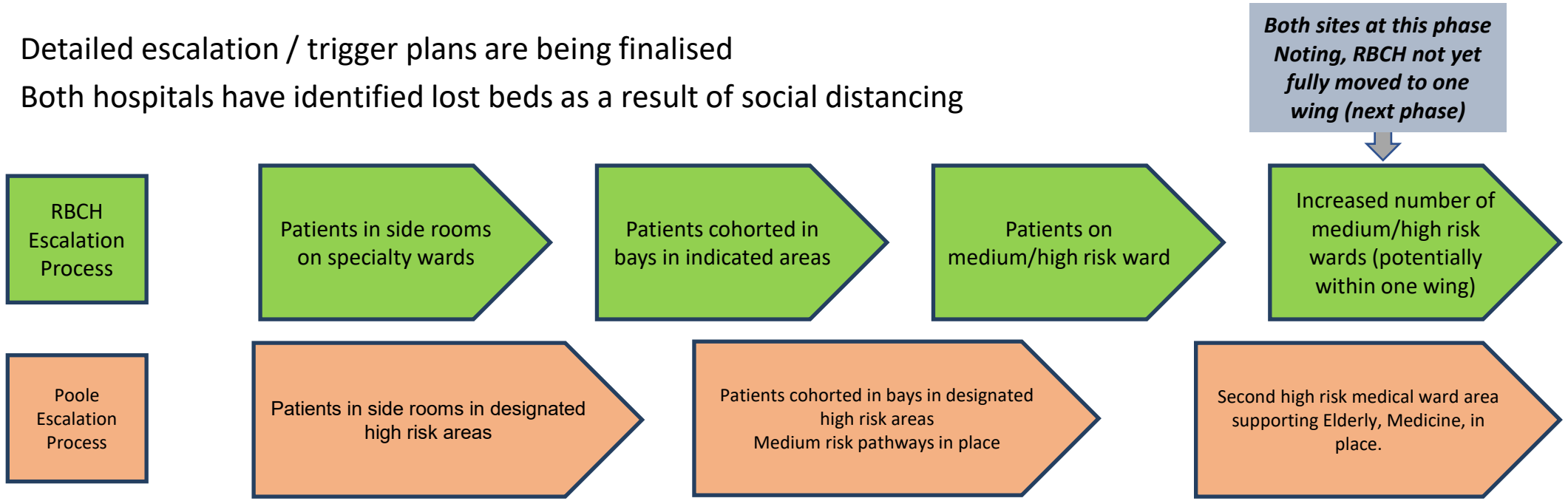
Escalation Plans – Inpatient Low/Med/High Risk Pathway Capacity

- Detailed escalation / trigger plans are being finalised
- Both hospitals have identified lost beds as a result of social distancing



Principles

- 2m distancing maintained pillow to pillow. As at 11 Nov 20 - **Currently reviewing plan to secure enhanced distancing within all admission areas (RBCH) to minimise impact on 'await swabs' flow and downstream asymptomatic / day 5-7 positives**
- IPC practices (e.g. masks, separate staff, etc)
- Separation of low and high (Covid) risk pathways (noting transitional periods as incidence increases)
- Medium risk 'await swab' flow pathways maintained through above 2m distancing
- Covid clinically likely admission through side room on to dedicated Covid ward
- Dedicated Covid/high risk plus/minus medium risk ward/s
- Very low risk ringfenced areas (isolated, negative swab pre surgery)

! Despite plan, ongoing challenges where experience does not play out according to plan i.e. 5-7 day positive tests !

Escalation Plans – Critical Care

RBCH Site – Trigger Level	Level 3 Equivalent Beds	Poole Site – Trigger Level	Level 3 Equivalent Beds
Level 1a Normal bed base and staffing template. All patients housed within the normal ICU footprint. Adequate number of side rooms for patients requiring isolation for infective processes/AGPs.	8	**Level 1** Normal bed base and staffing template. All patients housed within the normal ICU footprint. Adequate number of side rooms for patients requiring isolation for infective processes/AGPs.	8
Level 1b All side rooms in Green ICU full requiring an additional ICU nurse. Contact Poole ICU to explore possible transfers	8		
Level 2 Second COVID SUSPECTED/POSITIVE REQUIRING ADMISSION TO ICU triggers opening of BLUE ICU (CCU), or need for additional side room necessitates opening BLUE ICU	12	**Level 2** Second COVID SUSPECTED/POSITIVE REQUIRING ADMISSION TO ICU triggers opening of BLUE ICU (B2) (Additional nursing and medical staff required)	11
Level 3a All 4 side rooms on BLUE ICU filled (move to >1:2 ratio of ICU nurses and requiring non ITU nurses to support)	14	**Level 3** More than 11 level 3 equivalent patients (Additional Anaesthetic medical support required resulting in a loss of one elective theatre, a move to >1:2 ratio of ICU nurses and requiring non ITU nurses to support)	15
Level 3b Green ICU fully occupied. All 4 side rooms on BLUE ICU filled and 2 beds in main bay of BLUE ICU occupied	20		
Level 3 c BLUE ICU expands into CCU step down bays, impacting on loss of 5 medical beds. 1 Consultant becomes resident	29		
Level 4a Expansion into theatres (3&4) 2 with up to 3 patients per theatre/anaesthetic room. Backfill consultant cover with consultant anaesthetists (Loss of 2 elective theatres)	35	**Level 4** Open B2 Ward fully as ICU beds (loss of 19 surgical/trauma beds to maintain blue acute pathway will require escalation to transfer MFFD patients outside of the Trust and loss of at least one additional theatre dependent on ITU staffing needs)	32
Level 5 **INCIDENT MANAGEMENT RESPONSE**	**Incident management Response**	**Level 5** **INCIDENT MANAGEMENT RESPONSE**	**Incident management Response**

Site Name	Green Beds	Green Surge Beds	Amber Surge Beds
Bournemouth	11 (TOTAL 11)	3 TOTAL (14)	21 (TOTAL 35)
Poole	11 (TOTAL 11)	3 TOTAL (20)	18 (TOTAL 32)
		UHD TOTAL	**61**

Network Mutual Aid / Inter Trust Transfers

- Escalation plan in place across Network (UHD, DCH, SFT)
- South East CrC transfer service will support capacity transfers in Dorset/Salisbury subregion from mid December 2020
- Interim arrangement via escalation to Exec/on call for private enhanced care provider

Escalation Plans – Elective Care

- We are committed to delivery of our **Phase 3 plans** (see separate slides), which recover and maintain our elective and out-patient activity
- We have been reinstating our elective capacity based on our improved knowledge of the likely COVID impact
- We would envisage during 2nd wave Covid surge continuing with **at least** 50% of our main theatre capacity plus additional orthopaedic capacity aiming to deliver national activity targets (see separate **Phase 3 slides**). *Note, 50% would result in clinical prioritisation with focus on clinically urgent and cancer first.*
- Stepping down of any elective activity will be based on incidence, triggers and overseen by UHD Tactical Group, noting cancer and clinically urgent followed by long waiters, remain the first priorities.
    - *Triggers include Increase in COVID and Non – COVID presentations; ADDs > 24 and 48 hours;*
- Practices/pathways (inc swabbing / PPE / ventilation / cleaning) in line with IPC guidance on low / medium/ high risk (note we have identified fully or partially ring fenced areas for isolated, swab –ve, elective patients)
- Continue with current guidelines to ensure separation of Covid and non Covid treatment clinics - working with main theatres to relocate any further local anaesthetic cases to increase capacity

Location	Usage	Narrative
Poole Theatres	76%	All main theatres being used. 2 day theatres out - one will have new ventilation from November, other one from the New Year. Also running lists in the Harbour Hospital.
RBCH Theatres	74%	1 main theatre (3) currently undergoing refurbishment works – re open 15th October. Sandbourne theatres in operation. Day theatres to open from 12th Oct (Endoscopy have been utilising the theatres). Activity also currently undertaken at Nuffield (2 theatres). Saturday lists are also being undertaken.

Outpatients and diagnostics

OUTPATIENTS

- Continue & increase virtual clinics where appropriate - 40-50% at present (video-consultations & telephone consultations fully supported)
- Extend working day and weekend working
- Flexible use of resources across the 3 (UHD) hospital sites – workforce/clinic rooms/equipment
- Review external opportunities for clinic capacity where clinically appropriate
- Restricted numbers in waiting areas social distancing - collaborate with clinics to ensure limited numbers - or flow maintenance into sub wait areas
- Utilising ISP for Outpatient capacity in Q3

DIAGNOSTICS

- Front door SAMBA units supported by swabbing team/ward training with additional capacity coming online including 24/7 testing
- Patient only attendance e.g. for imaging (with appropriate exceptions)
- Extended days where staffing allows
- Careful cleaning in line with national guidance
- Continued clinical review of lists and referrals
- Respond to peaks in demand by flexing phlebotomy provision where appropriate to ensure timely sample collection and ensure rapid result turnaround. Recruit additional phlebotomy staff on fixed term contract to support winter ward.
- Restart and scale-up respiratory (e.g. Flu etc.) and GI (e.g. Noro etc.) virus testing
- Continue to explore different methodologies to ensure appropriate and timely COVID-19 testing
- Phased approach to de-escalation of elective, outpatient and diagnostic activity to release staff for Covid surge as required, subject to incidence/triggers and overseen by Tactical Group.

Workforce Recruitment & Escalation Plans - Nursing

- With the increased levels of Covid-19 in the community the Trust is seeing a rise in the numbers of nursing staff either off sick, self-isolating , shielding or repurposed. With the current levels safe staffing has been maintained using our existing trigger systems:
  - Red-flags measurements
  - Acuity and Dependency Monitoring using SafeCare
  - Professional Judgement
  - Minimum levels of acceptable staffing
  - Quality matrix monitoring
- Learning from the national picture plans are in place to review our local triggers and adjustments to care levels to deliver only basic nursing care if staffing levels were to be compromised, for example:
  - Delivering on essentials such as medicines, hydration, nutrition, wound care and toileting
  - Reducing admission paperwork to basics, omitting property assessments
  - Omitting some assessment tools such as frailty scoring / dementia assessment
  - Routine patient rounding reduced only to those at high –risk
  - Adjusting eNa frequencies around observation levels.
- On-going oversight of safe staffing levels undertaken on a daily
- Dependent on uptake there will need to be a consideration to reduce elective work to repurpose specialist nurses to staff areas
- Critical Care: in response to a change in national guidance for staffing, revisiting plans to achieve new recommendations (1 critical care nurse to two patients)
- Funding received of circa 25K to support expediting the recruitment of 15 international nurses across both sites, with further funding from HEE received to support enhancing the OSCE training for all international nurses working towards registration.

Workforce Recruitment & Escalation Plans - Medical

Ruth/Matt to review

RBH Site

- Medical cover for Medium/High risk wards in place
- Plans are being reviewed for medical cover for East Wing and/or further Medium/High risk wards and subject to single or mixed speciality model
- ICU have modelled up to 24 beds without significantly affecting other medical rotas.

Poole Hospital Site

- Escalation plans being finalised
- Winter escalation ward (OPS) already modelled
- ICU – escalation to 19 beds will not significantly affect rotas but some key nursing staff have been identified who would be called upon and this has been shared with matrons from the respective areas

General

- Ongoing and continual review of pathways and ward configuration
- Model for medical cover (e.g. mixed speciality Team approach, escalated rotas for enhanced senior and other cover) is being reviewed by DCMOs and GMDs
- Aim to have more flexible, phased approach to escalation/change in rotas
- Plan to preserve elective activity and pathways

Workforce

The following commenced in Covid-19 1st wave and continues to support monitoring and response should the trust experience a 2nd wave:

- Workforce reporting;
- Recruitment of supplementary workforce;
- Covid related HR advice – full guidance available on Trust intranet;
- Staff risk assessments across the trust, including for vulnerable staff
- Covid related induction and training;
- Enhanced Health and well-being support including support for staff shielding and for staff from a BAME background.

HR Cell to continue to work on plans, including:

- Promoting the Covid-19 hotline. This has been on-going, with calls have definitely increased over the last few days. Mostly questions around quarantine, self-isolating, school closures and staff swabbing – all in Q & As, but reassurance and guidance needed.
- To consider whether processes for FIT testing could be harmonised (already achieved for booking for staff swabbing) across both sites - currently different.
- Staff accommodation for anyone needing to isolate away from their household needs to be considered. OH planning to review risk assessment process
- Plans for a potential vaccine?
- Repurposing of staff could also be in the early plans - working from previous experiences.

Staff Wellbeing

A multi-specialty working group has continued to meet since the lockdown eased. Additional resource has been allocated within the UHD OD team to develop an holistic Staff Wellbeing package with our stakeholders. Work streams are being progressed across several areas in line with national recommendations;

- Leadership and culture
- Engagement and evaluation
- Healthy environment
- Physical wellbeing
- Healthy lifestyles
- Psychological wellbeing

Our Covid-19 2nd phase package;

Enhanced Psychological and Emotional Support

- Supporting staff through uncertainties over the next 6/12
- To continue with 12 months of additional resource for those in need of emotional support
- Working alongside BAME network colleagues to provide additional support, including risk assessments
- Bespoke team resilience support available and being accessed

Safe Spaces

- Safe spaces requires urgent re-provision. These were well utilised and were deemed an essential intervention whether temporary or permanent
- Charitable funding has been approved for permanent legacy re-provision of safe spaces

Team Charity Funding Pot - Local Recognition Fund

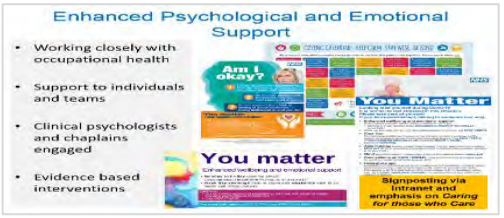
- Charitable funding has been approved for £10 for each staff member, the process to make this funding available to support team wellbeing is currently being agreed with Fundraising and Finance

Food and Hydration

- Coordinated effort to provide access to food and hydration will be ramped up as required

Staff Engagement and Involvement

- Intranet and communications will deliver current on message and latest advice
- Wellbeing hubs on all sites will be re-vamped providing central information points and someone to talk to



Personal Protective Equipment (PPE) Update

- Continue to follow Public Health England guidance in relation to PPE – supplies are still being 'pushed' from central reserves to both the Poole and Royal Bournemouth sites

- National aim is to maintain at least 14-days worth of stock on-hand at each location based on daily 'burn' rates reported to the national 'Palantir' data collection portal

- Recently the DHSC published a paper 'Personal Protective Equipment (PPE) Strategy - Stabilise and build resilience' outlining the forward strategy for PPE nationally, key points detailed include ….

  - … to ensure rapid response to demand surges in the future, DHSC are building a strategic stockpile of PPE equivalent to approximately 4-months stock of each product line. This will be stored in their warehouses and in place by November.
  - UK manufacturing capacity has been identified as important to achieving a more resilient supply chain. It is anticipated that in December around 70% of forecasted demand in England for all categories of PPE (excluding gloves) will be met from UK manufacturing.

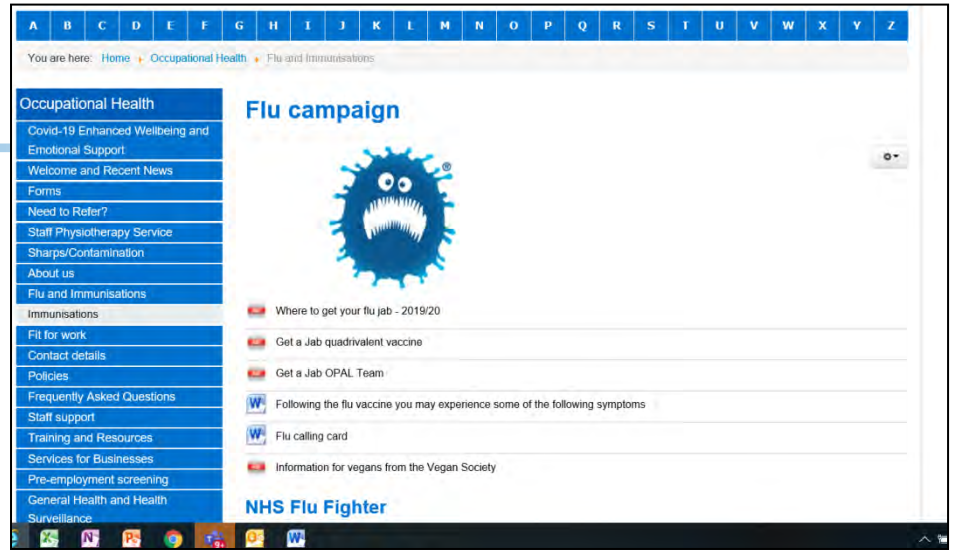
Medicines Update

- Medicines shortages are well controlled locally across all sites, although some central allocations of critical meds continue the situation has eased nationally.
- There is an agreement between the Trust pharmacy teams across SW region and TV/W for sharing of medicines where necessary.
- The Pharmacy Procurement team has been working as a single team for several months ahead of merger to manage shortages across the sites.
- Remdesivir is available on both sites. National update this week states demand has outstripped supply. National guidance re treatment protocol. Pharmacists are an essential part of the authorisation procedure.
- The pharmacy team across all sites collaborate on all work for COVID including clinical trials to ensure that processes are aligned as far as possible.
- Following review the Critical Care Teams on both sites agreed that aseptic preparation of parenteral doses by the pharmacy team was not necessary for the current bed base. This will be kept under constant review.
- Good communication between the clinical and pharmacy teams has been key to providing a responsive service.

Flu Vaccination

??add current progress

- Board commitment ambition to achieve 100% staff vaccination
- Nationally recommended flu vaccine will be ordered and provided for healthcare workers
- Anonymous collection of data on reasons for staff who decides against uptake
- Full communications plan in place
- Drop in clinics, 24 hour mobile vaccination schedule and flexible ‘bleep’ service
- Peer vaccinators
- Reviews of appropriate practice to support uptake in higher clinical risk areas



As part of the NHSE/I commissioning arrangements for seasonal influenza vaccination the Trust has committed to vaccinate pregnant women attending the Poole and RBCH maternity services. We are currently unable to provide vaccination to patients attending appointments in the ‘national at risk groups’ (over 18yrs) and those aged 65yrs.

Other Issues for awareness

Need review/update by Sophie/Alison/Abby??

- Independent Sector Capacity Update
  - Contract
    - National contract runs until end Dec, new contract now out to Expressions of Interest
    - Activity assumes NHS uses 75% of Nuffield and Harbour capacity
    - Weekly meetings to ensure we use this capacity
  - Currently using for:
    - Harbour – 1 x theatre mixed surgical
    - Nuffield – 1 x orthopaedic, 1 x mixed surgery plus some OMF
  - Now commencing:
    - Nuffield – Echo clinics; Thoracic rehab group; Thoracic outpatients; CT/MRI/plain film; Discussions re endoscopy
  - Operationally
    - Difficult - many patients don't want to come in and pre-op processes mean finding replacements for late cancellations more difficult
    - Management o be handed back to the Surgical Care Group
- CCG looking at further use of ISP to provide step down beds for MRFD patients
  - Risk to elective activity @ ISP

Covid-19 Risks/Issues - remaining under review

Area	Risk / Issue	Mitigation
Workforce	ED and Critical care staffing for new / escalation footprints. Winter/'replacement' bed capacity staffing (nursing, medical, other). Phase 3 recovery staffing (inc anaesthetists, orthopaedic surgeons, weekend working) Staff absence due to infection/isolation.	Business case prioritisation against funding allocations. Template reviewed led by CNO. Recruitment / block book / long lines. Care Group development of Phase 3 recovery plans. Repatriation of staff as backstop mitigation (noting consideration of Phase 3 recovery) National guidance around critical care and flexing nurse care
Health and Well Being	Staff resilience, stress, fatigue and uncertainty over next 6/12, particularly for a second wave and potential for lower levels of public support.	Detailed Organisational Development wellbeing support arrangements in place. Regular Comms to provide information regarding COVID position, Trust plans and response
Infection Control	Nosocomial transmission Bed and other capacity due to distancing and IPC pathways and practices See below re Testing Capacity / Swabbing.	Implementation of latest national IPC guidance, including low / medium/ high risk pathways and separation. Plan for winter / 'replacement' beds
Medication	Supply concerns Remdesivir demand	Local, regional and national network arrangements for mutual aid National guidance supporting treatment protocols Substitutes for key medicines
Supply Chain	PPE and other supplies, including lead time delays continue Swabbing kit/supplies remain a risk (incl. global outbreaks)	Higher level of PPE and other stock held locally and nationally and increasing UK manufacture. National allocations (note, lower levels of incidence in Dorset may remain a risk to Dorset facing supplies)
Training	Postponed training Reduced opportunity for training due to changed rotas (e.g. junior medical staff)	Better use of technology e.g. Teams based clinical seminars Plans for 2nd wave are for phased approach to reallocation of activities, preserving training as far as possible Some reallocation of staff provides new development opportunities

Covid-19 Risks/Issues - remaining under review

Area	Risk / Issue	Mitigation
Mortality	Variance HSMR / SHMI No current delays in issuing death certification (MCCD) ICNARC data inline with national average	Mortality reviews underway Medical examiner process in place
Communications	Staff and public reach and confidence Varied experience of COVID by geography and associated confusion for staff and public	Communication team to ensure local response to local COVID position for staff and public Full and escalating Comms plan – building on successes and learning from Covid 1st wave Comms team provide information regarding COVID position and Trust plans and response.
Front Door / ED	NHS 111 capacity – 111 First pilot has been delayed. Ambulance demand, capacity and process to deal with surges. ED staff templates for new footprints. Flow out due to bed occupancy / capacity / inpatient low, med, high risk pathways	DHC led 111 First programme – escalating capacity limitations Ambulance handover action plan Business case and template review SAMBA plus other new tests available early in admission process. Expediting capital development schemes.
Bed capacity	Loss of beds and flow as a result of social distancing, cohorting and low/med/high risk pathways. Transition from cohorting phase to whole ward – loss of beds during transition. Surges in demand exceed capacity. Bed occupancy /capacity increase if D2A not delivered (see below Home First risk)	Bed modelling undertaken and winter / 'replacement' beds planned (subject to funding allocation and staffing). Though remaining gap and full delivery of Home First and QI schemes required. Capital schemes drawn up to return non-ward areas to bed use, but long lead time and uncertainty of continuity of promised investment if resources diverted to higher priorities. Some of existing capital development adds single rooms.
Critical Care Capacity	Increasing capacity requires additional scarce staff and may result in reduction of elective activity.	Plan for escalation, using ward, theatre and recovery areas. Any elective reduction will be minimised.

Covid-19 Risks/Issues - remaining under review

Area	Risk / Issue	Mitigation
Home First Programme (D2A)	Lack of delivery of programme and continued levels of MRFD patients in hospital reduces capacity, increases occupancy, limits flow and increases deconditioning in patients. Impact of Christmas Holiday period on capacity across providers i.e. Domiciliary Care. Reliance on the short term / rapid response and reablement capacity needed to discharge on pathway 1. Impact of above on community bed provision. Currently experiencing shortage of domiciliary care package capacity, including large packages.	Exec led Dorset Home First Programme Board System wide escalation structure in place Visibility of the Trust's position through daily SITREP reporting
Non Covid, routine patient pathways	Increased number of patients waiting/waiting longer.	Phase 3 Reset & Recovery programme established (noting cancer and urgent activity well progressed). Elective activity will maintained at high level as long as possible. Will continue with prioritisation of patient (eg cancer, long waiters).
Screening	Testing capacity, especially fast turnaround Ability to swab and test staff and patients (particularly fast turnaround) due to test kits across Dorset (some improvement) Note: reduced incidence	National allocation of testing capacity (note, lower levels of incidence in Dorset may remain a risk to Dorset facing supplies). Portfolio of platforms to provide resilience (noting not all fast turnaround). Recruit additional members to swabbing and testing teams, utilising temp staff and staff unable to undertake other duties.

Dorset ICS Surge & Escalation Plan Draft

November 2020

Contents

Introduction

It should be noted that this plan is in draft for comment & agreement through H&SC Bronze TCG Operational and H&SC Silver Strategic

Introduction

- The key aim of this ICS Surge and Escalation Plan is to deal with measures to manage the surge of demand on services from seasonally affected conditions and increased risk relating to infection prevention and control outbreaks, and the potential risk of influenza together with measures to deal with the growing transmission of Covid-19.

- The plan identifies provider escalation level triggers which feed into the system level triggers which will enable prioritisation of essential services and free up system capacity.

- This plan needs to be read in conjunction with provider level Winter Plans, Escalation and Resilience Plans and the agreed system and provider OPEL triggers.

- The plan will support consistency in the declaration of OPEL levels across all organisations

System Leadership & Governance

There are three clear levels of System Leadership and Governance for communication and monitoring and agreement of escalation actions and decisions

- **Individual Provider Level** - IMTs within the trust regularly reviewing demand and capacity over 7 days per week

- **Dorset System H&SC Bronze TCG Operational -** Monday/Wednesday/Friday meetings with the flexibility to escalate to daily meetings 7 days per week as escalation triggers dictate

- **Dorset System H&SC Silver Strategic -** Monday/Wednesday/Friday meetings with the flexibility to escalate to daily meetings 7 days per week as escalation triggers dictate

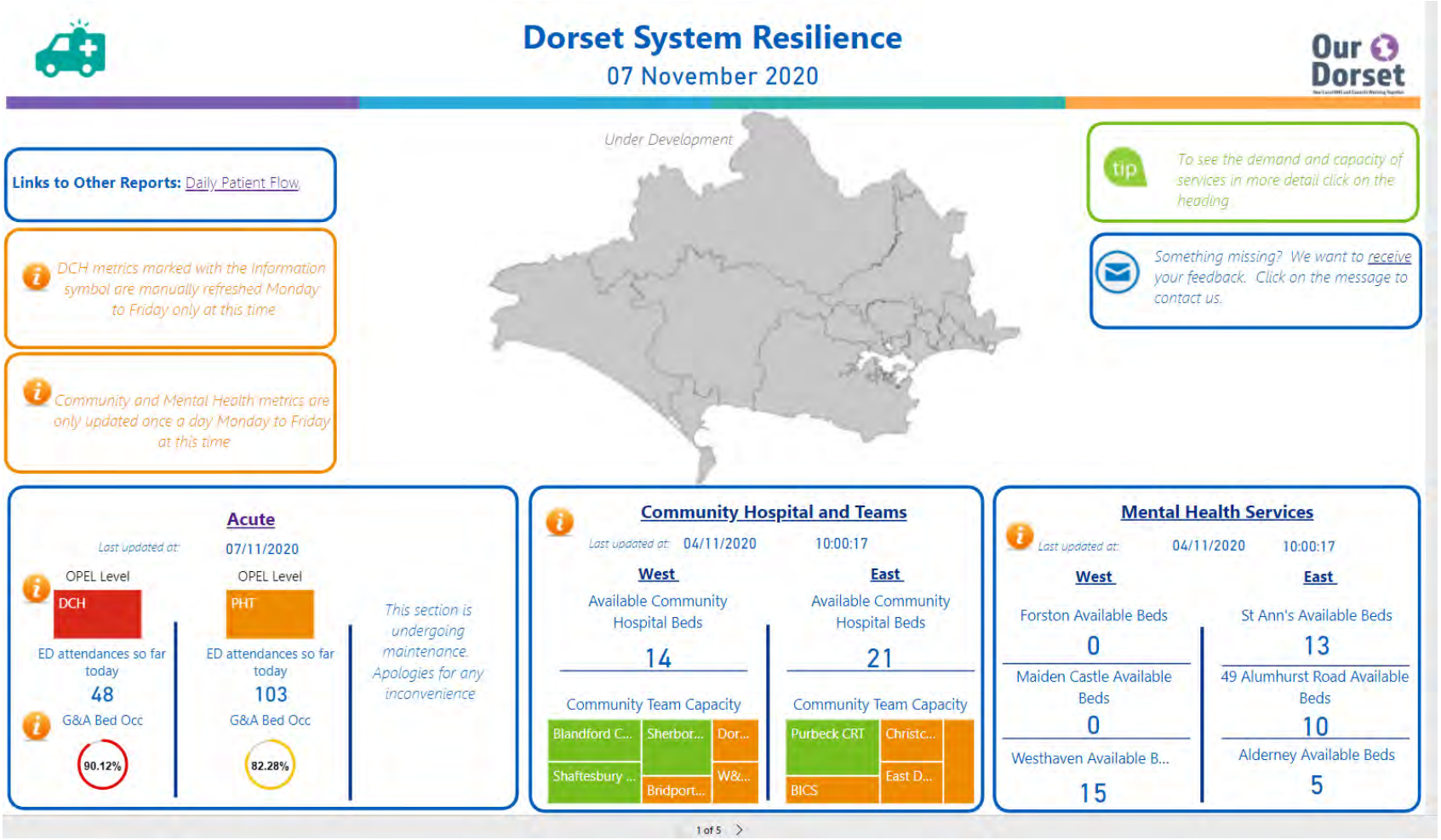
Three Phases of System Escalation

- Routine services delayed with potential harm to our population and risk to service users
- Significant delay to access critical services with potential for long-term harm for patients
- Risk of services becoming overwhelmed leading to potential loss of life due to service failure

Process for escalating between different phases of the Dorset ICS Surge & Escalation Framework

- Any organisation can request, through Bronze that the system moves between phases of escalation
- Bronze will consider level of system operational declaration based on presented information
- If Bronze is unable to agree sufficient actions to support system escalation and capacity, then recommendations will be made formally to Silver highlighting why the OPEL risk has changed
- Escalation of Provider Level 4 or System Level will be agreed at Silver and escalated via ROC to Regional Gold
- Silver will keep all actions under regular review to ensure the right balance between short term benefit and long term harm during escalation

Capacity Management System / Winter Dashboard



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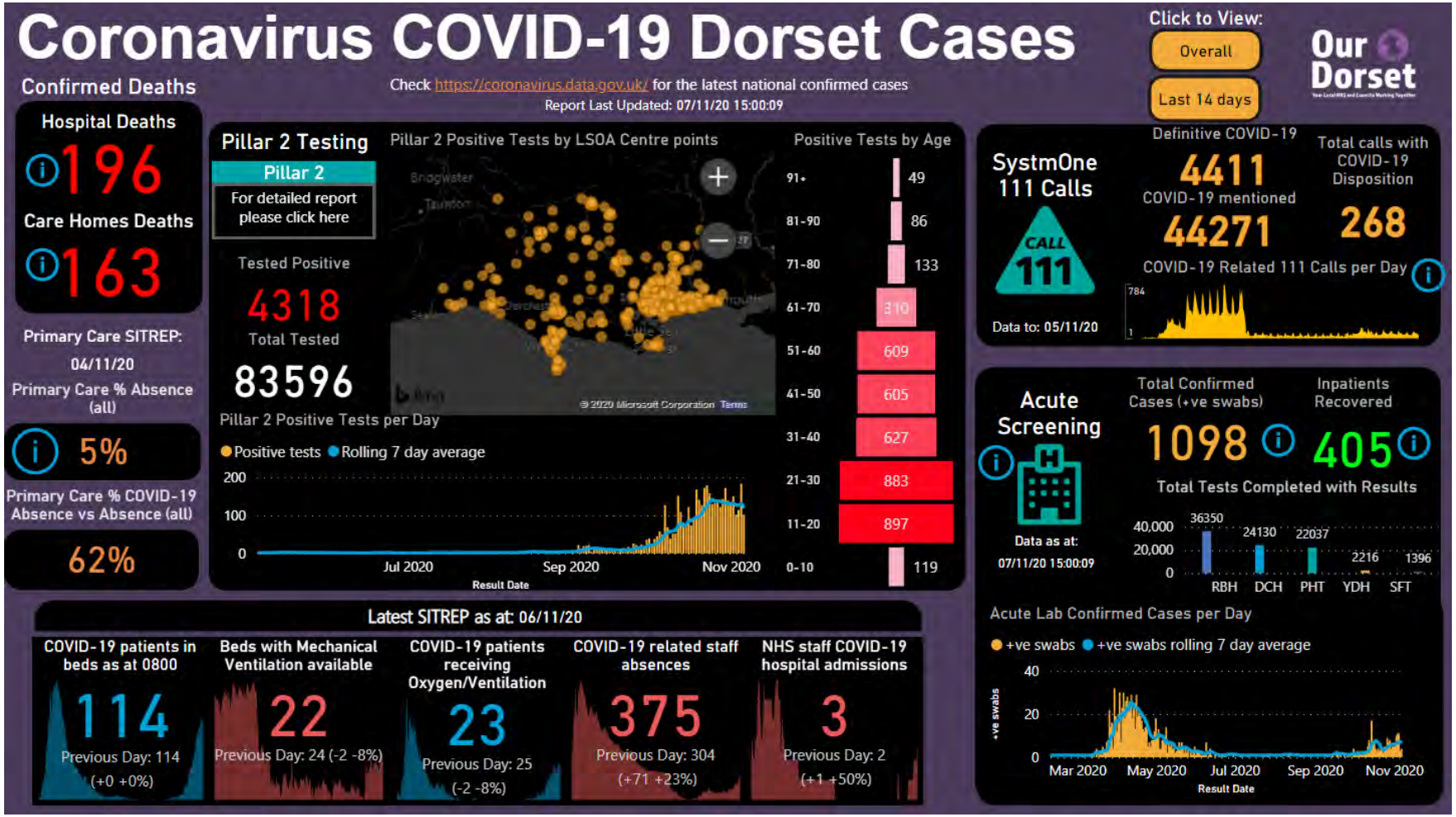
Covid – 19 Dashboard



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Provider-Level Healthcare Escalation Triggers (not finalised)

Escalation Triggers		A&E Performance	Number of Ambulance Handover Delays Over 15 mins	G&A Bed Occupancy	Beds Closed Due to IPC	Criteria To Reside Not Met %age of G&A	Staffing
OPEL 1	DCH	>95%	0	<75%	<2%	<1%	<2%
	UHD P	200mins	0	<75%	<2%	<1%	<2%
	UHD B	>95%	0	<75%	<2%	<1%	<2%
	DHC	>95%	-	<75%	<2%	<1%	<2%
	SWAST	-	-	-	-	-	<2%
OPEL 2	DCH	85%- 94.9%	0	76%-85%	<2%	1-5%	<3%
	UHD P	210mins	0	76%-85%	<2%	1-5%	<3%
	UHD B	85%- 94.9%	0	76%-85%	<2%	1-5%	<3%
	DHC	85%- 94.9%	-	76%-85%	<2%	1-5%	<3%
	SWAST	-	-	-	-		<3%
OPEL 3	DCH	75% - 84.9%	0	86%-95%	<2%	5% - 10%	<4%
	UHD P	220mins	0	86%-95%	<2%	5% - 10%	<4%
	UHD B	75% - 84.9%	0	86%-95%	<2%	5% - 10%	<4%
	DHC	75% - 84.9%	-	86%-95%	<2%	5% - 10%	<4%
	SWAST	-	-	-	-	-	<4%
OPEL 4	DCH	<74.9%	0	>96%	<2%	>10%	>5%
	UHD P	230mins	0	>96%	<2%	>10%	>5%
	UHD B	<74.9%	0	>96%	<2%	>10%	>5%
	DHC	<74.9%	-	>96%	<2%	>10%	>5%
	SWAST	-	-	-	-	-	>5%

Assumptions made:

- Normal acute flow achieved at 85% capacity
- To achieve flow with Covid-19, flow must be in the region of 75%
- G&A Bed numbers are deemed as **operational viable capacity**

Acute Hospitals Daily

If on these triggers, it is forecasted that demand is over forecasted capacity, and the provider is considering the reviewing and evaluation of elective activity, then the provider declares **OPEL 3**.

Triggers and escalation, including assumptions on mutual aid and Nightingales

There are provider-level triggers and system-level triggers, which result in a System-level response being actioned.

The OPEL Framework is the basis of the structure of these triggers and work is underway as detailed, in standardising the OPEL System Response.

Triggers are being developed that are more nuanced focussing across the UEC pathway as a whole, to understand the connections between then and have further system actions:

- 111 answering
- 999 call stack for Dorset
- Loss of primary care capacity due to Covid sickness
- Reduction in Dom Care capacity due to Covid
- Care home closures
- NEPTS
- MIU and UTC Utilisation

OPEL 1 Organisational Level

OPEL 2 Organisational Level

OPEL 3 H&SC Bronze Level

OPEL 4 H&SC Silver Level

Operational Pressures Escalation Levels	
OPEL 1	Four-hour performance is being delivered. The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The UEC Delivery Board will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	Four-hour performance is at risk. The local health and social care system is starting to show signs of pressure. The UEC Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. System partners will keep ALB's at subregional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3	Four-hour performance is being significantly compromised. The local health and social care system is experiencing major pressures compromising patient flow, and these continue to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all UEC Delivery Board partners, and increased external support may be required. Regional teams in the ALB's including the Regional Director will be made aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. Decisions to move to system level OPEL 4 will be discussed between the Trust CEO, the CCG AO, and System leadership (CCG/ ICS Director). This should also be agreed with the Regional Director, or their nominated Deputy. The National UEC Operations team will be immediately informed by the Regional UEC Operational Leads through internal reporting mechanisms.
OPEL 4 (whole system)	Four-hour performance is not being delivered and patients are being cared for in overcrowded and congested department(s). Pressure in the local health and social care system continues and there is increased potential for patient care and safety to be compromised. Decisive action must be taken by the UEC Delivery Board members to recover capacity and ensure patient safety. If pressure continues for more than 3 days an extraordinary UECDB meeting should be considered. All available local escalation actions taken, external extensive support and intervention required. Regional teams in the local ALB's will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. The Regional UEC Operations Leads will have an ongoing dialogue with the National UEC Ops Room providing assurance of whole system action and progress towards recovery. The key question to be answered is how the safety of the patients in corridors is being addressed, and actions are being taken to enable flow to reduce overcrowding. The expectation is that the situation within the hospital will be being managed by the hospital CEO or appropriate Board Director, and they will be on site. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Workforce Triggers & Plans

- **Provider Level**

  Provider Level Workforce Plans in place to support routine and escalation

- **H&SC Bronze**

  Mutual aid / Workforce to support escalation capacity/empty bed

- **H&SC Silver Strategic**

  With support from DWAB system mutual aid and staff deployment from agreement of the stepdown of BAU services

Workforce Mutual Assistance

Purpose and definition: consistent with scope of this plan, health and care partners can request additional and reciprocate workforce related assistance in response to fluctuating organisational demands. This support is likely to include temporary deployment of staff, induction and training, and enhanced health and wellbeing support.

Scope: this framework is ***not*** intended to replace the business continuity arrangements at an organisational level. The framework provides a second tier approach to coordinating the temporary deployment of ***defined cohorts*** of staff in order to maintain and, if agreed by H&SC Silver, increase services to respond to escalating demand. The following services are in scope: ***Bronze to define,*** critical care and the roll out of the Covid-19 mass vaccination programme.

Workforce Mutual Assistance

The **benefits** are intended to minimise the risk of health and care partners 'withdrawing' critical services as a result of workforce capacity and capability shortages, by maximising and appropriately deploying the total workforce across Dorset in response to real time surges in demand. We must ensure that consistent and appropriate mechanisms and safeguards are in place to enable existing and new staff to work across different teams and organisations.

Workforce mutual assistance will be underpinned by the following **guiding principles:**

- respecting and mitigating the risk of destabilising services as a consequence of staff shortages;

- working together to avoid any surprises which will impact on other partners;

- enabling staff to fully utilise their skills where and when they are needed the most; and

- responding to short term sustainability and or service expansion demands.

Workforce Triggers & Escalation

Triggers	Role of H&SC Bronze	Role of H&SC Silver	Role of Workforce Cell (to be delivered through ICS workforce team)
General Surge (winter pressures)			
• Patient acuity exceeds existing staffing levels (daily matron assessment), leading to safety risks • Significant gaps in specialist areas or key services that cannot be covered through any means internally, or via agency • High numbers of unplanned absence which cannot be covered at short notice leading to patient safety risks • Adverse weather conditions that prevent clinicians/key staff being able to get to work	Escalation of request to include details of: service, location, role, skills, competencies, duration, shift pattern(s) Endorsement and formal escalation to H&SC Silver, including potential options and interdependencies e.g. deployment of existing staff, bank staff, agency staff	Decision to approve/decline the requests, taking into consideration the control measures and independencies, including: - temporary suspension / reduction of other services in order to release workforce capacity - prioritisation and redeployment of staff to meet demand / relieve pressure points - incentivising existing staff, including bank staff - financial considerations and controls	Working with HR/Workforce partners, facilitation of: - temporary redeployment, utilising existing MOU where possible or Our Dorset Passport - induction and training - attraction and recruitment campaigns
Social Care – in development			
If a GP practice has significant gaps in staffing, it is expected that mutual aid will be within the PCN. The PCN will be responsible for escalating pressures with a view to mutual aid from the wider primary care system. (Triggers in development)			
Critical Care			
Wessex Critical Care Network	As above	As above	As above
Mass Vaccination (Covid-19)			
Wider Dorset ICS discussion between Workforce and Vaccination Cell.	As above	As above	As above

Preparatory work to support Workforce Mutual Assistance

Workforce Cell	H&SC Bronze	H&SC Silver
Review lessons learnt from the redeployment of staff during the first wave of Covid-19	Define the services, staff groups, and 'work' likely to be requested	Formally adopt the mutual assistance principles for workforce redeployment in the context of this framework
Prepare staff and organise staff induction	Development of communications for bank staff, including highlighting the importantly for staff to	
Consideration of incentives for existing staff, including staff working on bank contracts		
Work with agencies to increase capacity for specialist roles e.g. critical care		

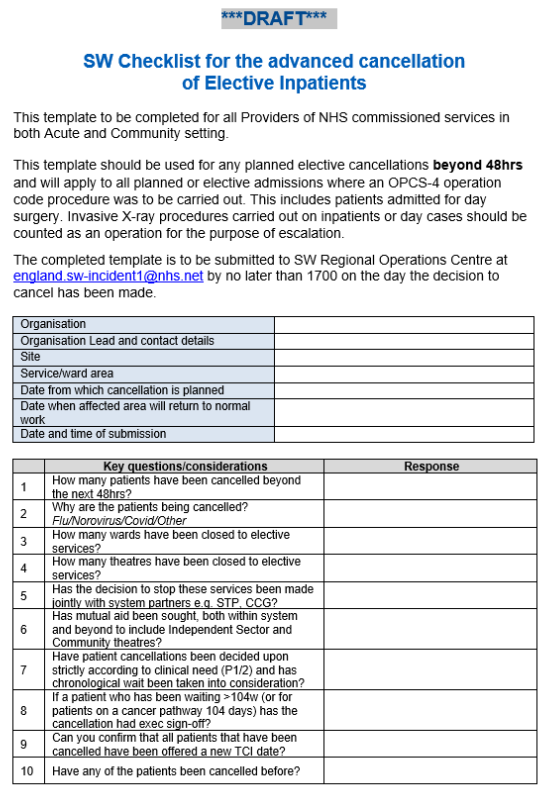
Elective Pacing & Stand Down of Services

- **Provider Operational -** Planned elective pacing as per Winter Plans

- **H&SC Bronze -** Provider OPEL 3 or at operational system level moving into system OPEL 3, Bronze will review, evaluate and consider an individual providers request to cancel all or reduce elective capacity
  - ITU capacity availability for elective care
  - Inpatients & Day surgery
  - Diverts for maternity and children's service if possible
  - Diverts of GP referrals from the affected provider

- **H&SC Silver Actions**
  - Escalation to Silver for request to cancel planned electives across system – all urgent Cancer to continue unless ITU Green capacity compromised
  - Formal request of ambulance diverts

- **Regional Gold**
  - Escalation as per SW checklist via Regional ROC review daily



DRAFT

SW Checklist for the advanced cancellation of Elective Inpatients

This template to be completed for all Providers of NHS commissioned services in both Acute and Community setting.

This template should be used for any planned elective cancellations **beyond 48hrs** and will apply to all planned or elective admissions where an OPCS-4 operation code procedure was to be carried out. This includes patients admitted for day surgery. Invasive X-ray procedures carried out on inpatients or day cases should be counted as an operation for the purpose of escalation.

The completed template is to be submitted to SW Regional Operations Centre at england.sw-incident1@nhs.net by no later than 1700 on the day the decision to cancel has been made.

Organisation	
Organisation Lead and contact details	
Site	
Service/ward area	
Date from which cancellation is planned	
Date when affected area will return to normal work	
Date and time of submission	

	Key questions/considerations	Response
1	How many patients have been cancelled beyond the next 48hrs?	
2	Why are the patients being cancelled? *Flu/Norovirus/Covid/Other*	
3	How many wards have been closed to elective services?	
4	How many theatres have been closed to elective services?	
5	Has the decision to stop these services been made jointly with system partners e.g. STP, CCG?	
6	Has mutual aid been sought, both within system and beyond to include Independent Sector and Community theatres?	
7	Have patient cancellations been decided upon strictly according to clinical need (P1/2) and has chronological wait been taken into consideration?	
8	If a patient who has been waiting >104w (or for patients on a cancer pathway 104 days) has the cancellation had exec sign-off?	
9	Can you confirm that all patients that have been cancelled have been offered a new TCI date?	
10	Have any of the patients been cancelled before?	

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The Escalation Process

Escalation Level	Acute Trust (s)	Community Care	Social Care	Other issues
OPEL One	• Demand for services within normal parameters • There is capacity available for the expected emergency and elective demand. No staffing issues identified • No technological difficulties impacting on patient care • Use of specialist units/beds/wards have capacity • Good patient flow through ED and other access points. Pressure on maintaining ED 4-hour target • Infection control issues monitored and deemed within normal parameters	Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	Social services able to facilitate placements, care packages and discharges from acute care and other hospital and community based settings	NHS 111 call volume within expected level
OPEL Two	• Four-hour performance is at risk • Anticipated pressure in facilitating ambulance handovers • Insufficient discharges to create capacity for the expected elective and emergency activity • Opening of escalation beds likely (in addition to those already in use) • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services • Lack of beds across the Trust • ED patients with DTAs and no action plan Capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO)	• Patients in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services	• Patients in community and / or acute settings waiting for social services capacity • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) • Lower levels of staff available, but are sufficient to maintain services	• Rising NHS 111 call volume above normal levels • Surveillance information suggests an increase in demand • Weather warnings suggest a significant increase in demand
OPEL Three	• Actions at OPEL 2 failed to deliver capacity • Four-hour performance is significantly compromised • Significant number of handover delays • Patient flow significantly compromised • Unable to meet transfer from Acute Hospitals within 48-hour timeframe • Awaiting equipment causing delays for a number of other patients • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow Serious capacity pressures escalation beds and on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc) that can't be rectified within 2 hours	• Community capacity full • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Social services unable to facilitate care packages, discharges etc • Significant unexpected reduced staffing numbers to under 50% (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Surveillance information suggests a significant increase in demand NHS111 call volume significantly raised with normal or increased acuity of referrals • Weather conditions resulting in significant pressure on services • Infection control issues resulting in significant pressure on services
OPEL Four	• Actions at OPEL 3 failed to deliver capacity • No capacity across the Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances / Exceptional increase in ambulance attendances • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Infectious illness, Norovirus, Severe weather, and other pressures in Acute Trusts (including A&E handover breaches) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc) that can't be rectified within 4 hours • Four-hour performance is no longer being delivered, and patients are being cared for in overcrowded and congested emergency departments	• No capacity in community services • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	• Social services unable to facilitate care packages, discharges etc • Significant unexpected reduced staffing numbers to under 50% (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	

The Escalation Process – Primary Care (in development)

Is the practice currently able to provide core GMS/PMS services based on current demand?

Operational Pressures Escalation Level

The descriptions of OPEL are intended as a guide and cannot be expected to reflect all possible challenges or local circumstance but are intended as a general guide

OPEL 1

- All services are being delivered normally with normal levels of planned absence / staff sickness.
- No exceptional services being required/ requested from the system or patients.
- Demand being met within existing capacity
- No influence on capacity to deliver services from environmental factors. E.g. flooding /snow and visits
- All infrastructure working to normal levels of functionality with no impact on patient service delivery

Under OPEL 1 practices are likely to manage services within existing capacity and no further escalation is required

OPEL 2

- Pre-planned services are being disrupted
- Acute same day services are having to be prioritised/ administration activities being postponed in favour of patient facing activities.
- Demand from patients to see clinicians is elevated above normal levels
- Teaching and meetings are being postponed to provide additional patient facing capacity
- A single prominent disease or concern about a disease is presenting to the practice producing exceptional demand which is being managed by adaption of practice capacity for same day delivery
- Environmental factors are impacting on service capacity particularly visiting, but it is still possible to undertake these operations and meet demand
- Infrastructure failure sufficient to require altered methods of working e.g. loss of past medical history or resorting to paper methods, but not sufficient to cancel services particularly acute same day services

Under OPEL 2, practices are likely to manage services within existing capacity or within PCN and no further escalation is required. CCG will provide specific support to practices where required.

OPEL 3

- All services are being disrupted
- Leave, and/or rest periods (half days) cancelled
- All services are being disrupted with only essential services possible despite flexing of capacity
- Demand from patients to see clinicians is elevated significantly above normal levels
- Cancellation of routine/planned activity and delivery of acute same day access is being affected
- A single prominent disease or concern about a disease is presenting to the practice producing exceptional demand which is no longer being sustainably managed
- Environmental factors are impacting on service capacity particularly visiting, with some services no longer possible using current resources e.g. visiting
- Infrastructure failure significantly impacts ability to provide acute same day access despite all mitigation. E.g. emergency contact arrangements, no access to business continuity clinical systems Partial loss of access to premises

Under OPEL 3, Dorset CCG will escalate issues via the Dorset System H&SC Bronze Tactical Command Group. Resilience support will be requested from wider PC/H&SC providers.

OPEL 4

- Emergency PC services are being disrupted
- Ability to provide Emergency services are being impacted due to staffing levels
- Despite all measures being undertaken patient demand for same services cannot be met
- A single prominent disease or concern about a disease is presenting to the practice producing exceptional demand which cannot be managed using all practice level arrangements, e.g. alternative methods to deliver essential services are being employed
- Environmental factors are impacting on service capacity are overwhelming practices ability to provide emergency services
- Complete infrastructure failure requiring either relocation or support from other practices/agencies to handle calls to provide emergency services

Proposed Other Escalation Triggers

- Mental Health Capacity Beds and Teams
- Primary Care
- MIU and UTC Utilisation
- Care capacity in the community – beds and packages of care
- NEPTS

Further work to be done w/c 7/11 to determine OPEL triggers

Dorset Winter Communications Plan – 2020/21

This strategy and plan has been developed locally in Dorset to coordinate the communications to support winter across Dorset (the Dorset Integrated Care System) in 2020/21.

The aim is for the plan to ensure that messaging is clear across Dorset. It is likely that the winter period will be challenging, with the flu season coming during the current COVID-19 global pandemic, together with the potential of higher urgent care attendance, and winter pressures on NHS services. One of our key priorities is to have a specific focus on communicating with seldom asked/engaged groups.

The plan has been produced in the context of the Dorset Flu Communications and Engagement Plan 2020/21, the NHS E/I South West Regional Flu Communications Plan 2020/21, supporting the national NHS Winter Pressures Campaign Plan, Health and Care Silver, the Dorset COVID-19 Health Protection Board and Outbreak Management Plan, the national Public Health England Flu Immunisation Plan.

Objectives:

- To inform and educate the general public in Dorset on what the NHS do to plan and prepare for winter.
- Increase uptake of flu vaccinations with key target groups
- Signpost the right NHS services better over winter

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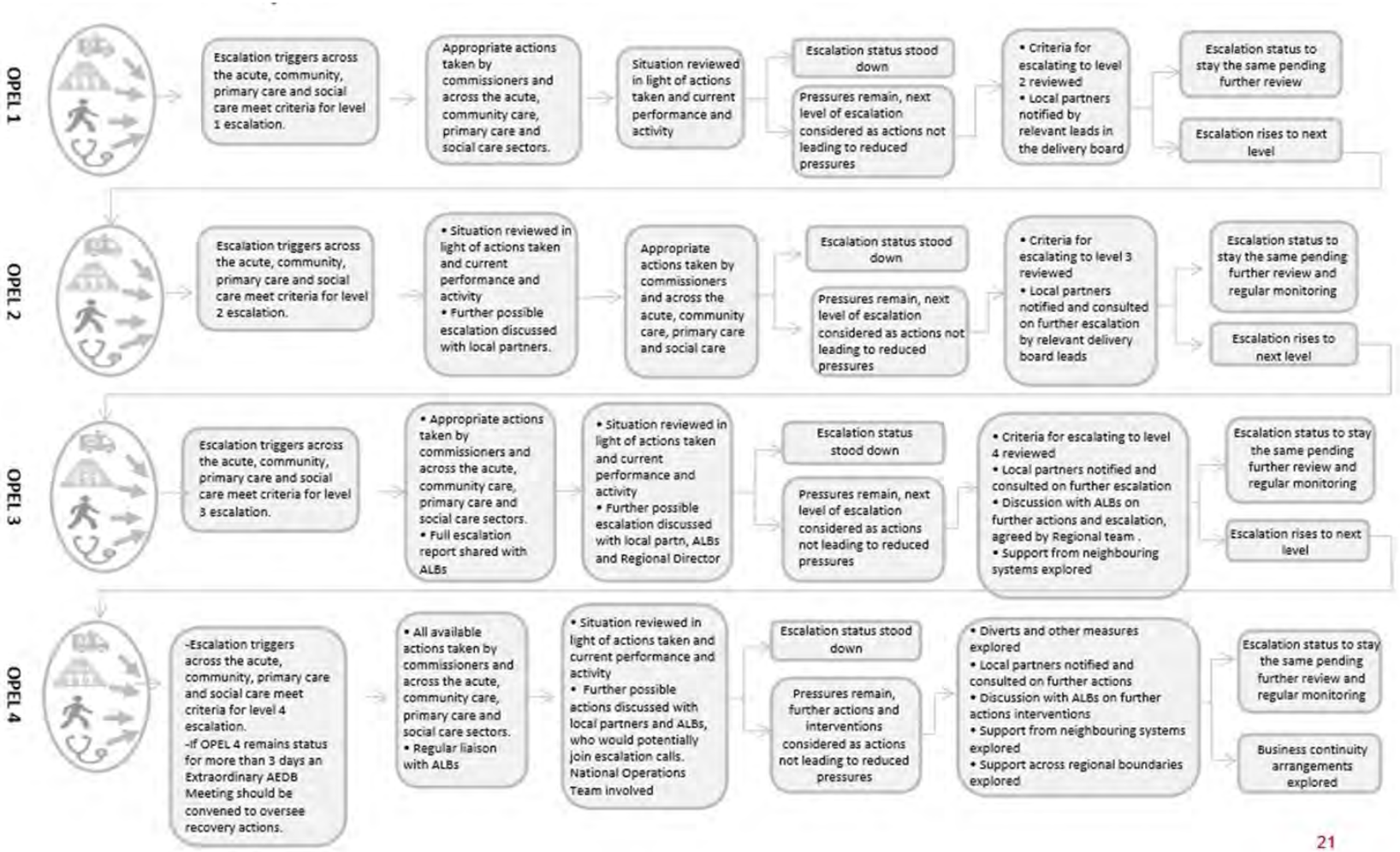
Local Escalation Processes



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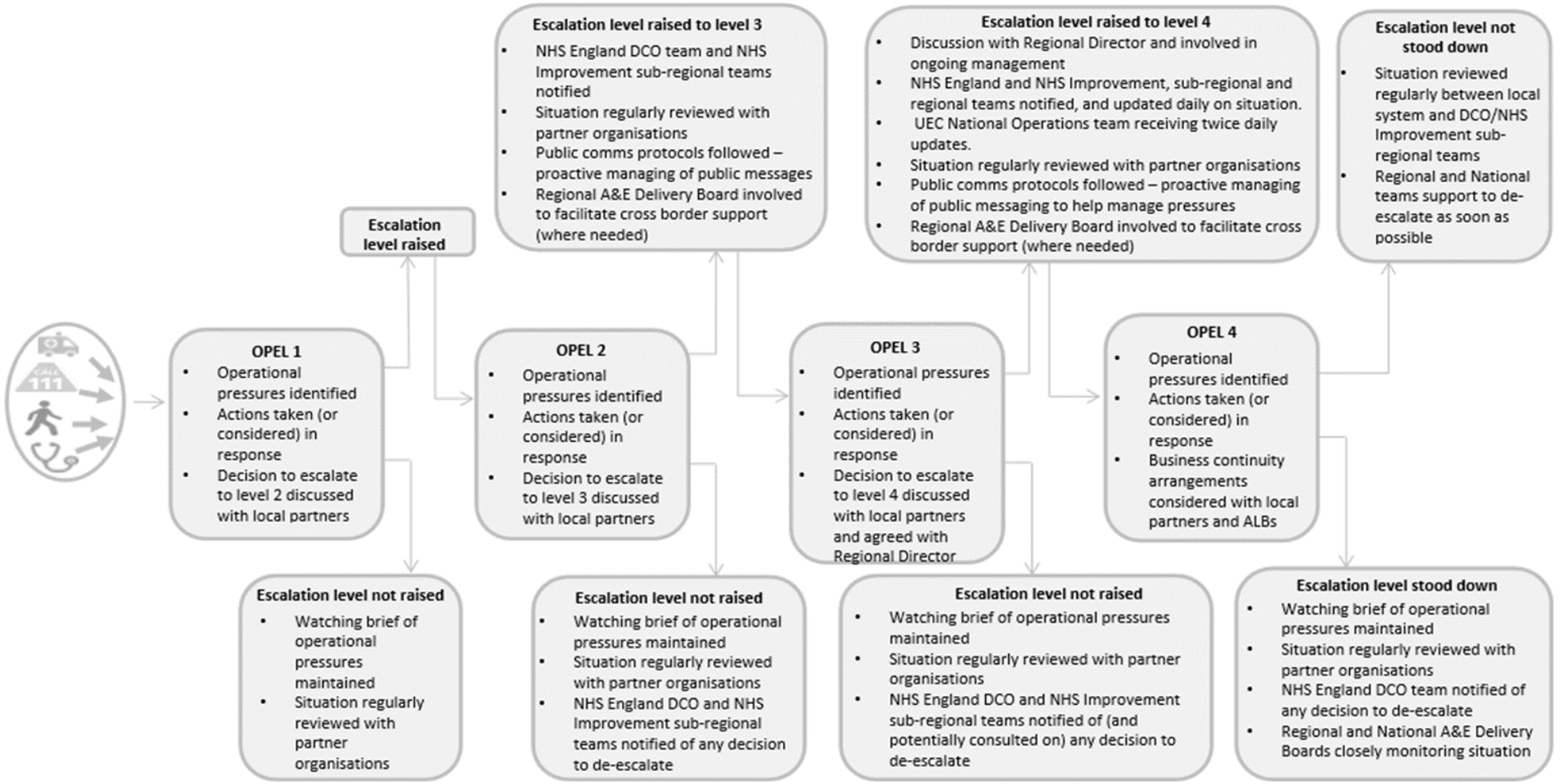
Escalation and with Local partners NHSE/I



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University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: Wednesday 25th November

Agenda item: 8.2

Subject:	University Hospitals Dorset NHS Foundation Trust Integrated Performance Report (IPR) October 2020

Prepared by:	Executive Directors, Donna Parker, Jackie Coles, David Mills, Fiona Hoskins, Louise Hamilton-Welsh, Andrew Goodwin
Presented by:	Executive Directors for specific service areas

Purpose of paper:	To inform the Board of Directors and Committees members on the performance of the Trust during October 2020 and consider the content of recovery plans.
Background:	Our integrated performance report (IPR) will be published monthly and includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It gives the public and staff better quality information about the performance of our hospital in the areas that matter to them. It shows the indicators that are used to measure performance for each of the Trust's operational areas and how well key services are delivering. The IPR is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny. The document provides a single 'shared truth' of performance across the organisation. The October IPR now includes a *'performance at a glance'* aligning to the CQC framework. All NHS organisations received a letter from Sir Simon Stevens (Chief Executive NHSE/I) and Amanda Pritchard (Chief Operating Officer NHSE/I) on 31st July detailing the third phase of the NHS response to Covid-19. **Key priorities for the rest of 2020/21:** • Accelerating the return to near-normal levels of non-Covid health services. • Preparing for and managing winter demand pressures, alongside continuing vigilance in the light of Covid-19 spikes locally and nationally. • Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention

Key points for Board members:

Areas of Board Focus

1. Increasing number of covid positive patients occupying beds has the potential to further increase the number elective patients waiting for treatment. The level of staff sickness to maintain all services during the 2nd wave covid and the impact this may have on the fundamentals of care. Increased future costs of addressing the number of patients waiting treatment. Impact on hospital reputation.

2. Increased occupancy across the organisation reducing hospital flow, creating increased pressures in the emergency departments/admission portals and ambulance handover and wait to be seen times. Potential impact on patient experience. Current number of patients who are medically ready to leave and not meeting criteria to reside. Workforce availability to meet escalating capacity levels, driving increased agency costs and potential impact on quality. Impact on hospital reputation.

Operational Performance

Emergency Care

Following merger, the Royal Bournemouth Hospital site is moving towards the reporting of the proposed new urgent and emergency care standards as a University Hospitals Dorset wide approach. This will join the Poole Hospital site which had been one of 14 trusts across England to test these. Internally, during the transition, we are continuing to monitor the traditional 4 hour standard on the Royal Bournemouth Hospital site. Guidance is expected confirming national metrics for EDs

Operational (Field testing standards) and Internal Care Standards

(colours based on change from last month)

		Oct-20		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	210 mins	226 mins	219 mins
Time to assessment	15 mins	3 mins	7 mins	5 mins
Internal Care Standards				
Time to triage (*RBCH: to assessment*)	15 mins	3 mins	7 mins	5 mins
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	73 mins	101 mins	89 mins
Time waited for a bed (*RBCH: DTA to left dept*)	60 mins	149 mins	91 mins	120 mins

4 Hour Standard – RBH (internal)

Monthly Performance YTD		2020/21 Totals (All Types)			2019/20 Totals (All Types)		
		Attends	Total Breaches	Total Performance	Attends	Total Breaches	Total Performance
Q1	Apr-20	4509	374	91.71%	8889	789	91.12%
	May-20	6190	397	93.59%	9344	679	92.73%
	Jun-20	7009	617	91.20%	9157	1266	86.17%
Q2	Jul-20	7967	963	87.91%	9778	1584	83.80%
	Aug-20	8494	1802	78.79%	9565	1614	83.13%
	Sep-20	7941	1767	77.75%	8946	1647	81.59%
Q3	Oct-20	7803	1992	74.47%	9241	1597	82.72%

The other key emergency care related standards/metrics are:

- Ambulance handover delays – *executive meeting with commissioners following requirement to reduce delays, noting number of 15/30 min breaches and average handover times against regional benchmarking*
- Occupancy, flow and criteria to reside (long waits for medically optimised for discharge patients) – *Occupancy and bed days attributable to long waiting patients increasing*

Emergency Dept
Both departments saw a reduction in attendances in October and levels remained below last year's. A higher level of ambulance conveyances at the RBH site, together with surges, as well as increasing acuity and staffing gaps, meant key metrics (*mean time/4hr/ambulance handover delays*) continued to be challenged. Increasing acuity and an increase in non-elective admissions also impacted on occupancy at the RBH site. Conversely, Poole site saw a slight reduction in conveyances and and improvement in clinician seen time. However, acuity, occupancy and flow challenges meant an increase in 'time to a bed' and 'mean time'.

Overall ambulance conveyances were higher than in September, but consistent with October 2019. The Trust has refreshed work on ambulance handovers and had an executive meeting with commissioners in early November to review the recovery plan and agree future monitoring. The joint ED action and recovery plan is the subject of a Board seminar in November. The workstreams are also incorporated with the governance structure for the UHD Urgent & Emergency Care Quality & Performance Improvement Programme.

Capital works are due to commence imminently in both departments following successful national bids to support infection control, same day emergency care and ambulance flow and handovers.

Occupancy, Flow and Discharge
Higher acuity and occupancy (increased to 86%) was born out in longer waits for a bed at the front door, which was exacerbated by longer lengths of stay and swab turnaround times. Over 7, 14 and 21 day patients increased in October. The Home First Programme and internally supporting D2A workstreams continue, though a number of challenges have remained. In particular, a lack of community and social care capacity for Covid positive patients is limiting discharge from acute and community hospitals. The level of Medically Optimised for Discharge patients continues to be escalated to executive level across the system and we are currently working closely with partners on plans/options for additional care home beds, care hours and community hospital beds. The Exception Report within the IPR provides further detail of the challenges and actions being taken.

Maintenance of our low / medium / high risk (Covid distancing and IPC) protocols, increasing Covid incidence across patients and staff, Covid related bed closures and staff absence continues to place additional pressure on flow. This is overseen by daily site based Flow meetings, with escalation to the joint UHD Tactical and Strategic Groups as required.

Surge and Escalation Planning

Our Winter and 2nd Wave Covid Plans remain under regular review and are being reviewed at Dorset and Regional executive level in November. These include plans for additional beds, workforce, critical care, as well as escalation plans based on increasing incidence/admissions, bed closures and staffing levels, amongst others. We continue to strive to maintain our elective Phase 3 plans, though noting pressures on all inpatient areas are increasing. System support for the discharge of Medically Optimised patients will be key.

Following completion of the 1st phase of capital works to improve the Frailty Unit, the next level of planned winter beds were opened on the RBCH site. Poole site have also progressed additional winter bed phasing.

Factors impacting on standards and flow

Demand	• Attendance levels, in particular, surges • Increases in ambulance arrivals and/or surges (e.g. 15+ conveyances/majors attends in 1 hour are increasingly experienced) • Increases in acuity and non-elective admissions
Clinical Processing Capacity	• Clinical staffing capacity to manage the department footprints and medium / high risk pathways (incl PPE/IPC practices) • Time to 1st clinician seen time (mean) tracking above the 60 mins standard • Clinical capacity available within the 111 Service can impact on increasing urgent care attendances.
Bed Capacity/ Trust Occupancy	• Increasing bed occupancy (now over 85%) • Beds closed for distancing, Covid wards or cohorting • Beds required for Covid Reset & Recovery activity (e.g. surgery) • No. of patients in the beds over 7 & 21 days driving up average length of stay (52% increase in daily beds occupied by patients over 21 days Sept vs July) • Increased use of escalation and/or outlying beds to maintain capacity • Covid swab turnaround times impacting on flow out of admissions units

High Level Actions being taken

Work continues against a number of the high level actions across both Trusts (see table below), including:

- First pilot of 111 First at RBCH completed, *noting delay in next pilot due to 111 capacity*
- Combined UTC/Minors front doors
- Ambulatory model within Poole ED
- Bed planning against modelling
- Frailty pathway commenced at RBCH
- Home First programme board and work stream priorities implemented from 1 Oct implementation, *noting backlog capacity limitations remain*
- Capital Investment to improve flow of both departments

In addition our Winter Plan and 2nd Wave Covid Plan are continually

being refined, alongside developing our Urgent & Emergency Care plans for our UHD improvement programme.

Referral to Treatment (RTT)
Providers and commissioners are required to plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2021 than in March 2019. At the end of October 20 there were 44,320 patients on the waiting list, more than the combined March 2019 position of 42,587. There are 2,998 patients waiting over 52 weeks, an increase of 362 patients from last month but within the trajectory shared with the South West region.

	Mar 19	Sept 20	Oct 20	
Waiting List Size	42,587	43213	44,320	**+1,733 v March 19**
Referral to treatment 18 week performance		56.2%	60.4%	**+4.2% v Sept 20**
RTT incomplete pathways >52+ weeks		2636	2,998	**+362 v Sept 20**

The waiting list has increased in the last 3 months with a corresponding drop in backlog of patients waiting over 18 weeks, this has resulted in an increase in performance from 56.2% to 60.4%%. Whilst the number of patients waiting over 18 weeks has reduced, there has been a rise in patients waiting over 40 and 52 weeks.

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Factors impacting on standard

Clinical Processing Capacity	The Trust's 18 week RTT performance is 60.4% against the 92% standard; this is mainly due to the impact of COVID-19 and the need to cancel elective work in Quarter 1 in line with national guidance and restoration of routine elective services safely during Quarter 2. Recognition of the challenging position of electives in Dorset also is a factor prior to Covid. Elective activity is recovering however productivity remains lower than previous years due to restoring services safely in line with national and clinical infection control guidance which make each procedure take much longer. The growing number of 52 weeks is mainly due to lack of theatre / treatment capacity. This waiting list is clinically reviewed and prioritised to reduce any potential harm for those patients waiting longer than expected for their procedure.

High Level Actions:

- Restoration plans are focused on increasing additional elective capacity to undertake elective procedures including, National contract to use the Independent Sector, outsourcing services using other local NHS and private providers, insourcing services to provide additional theatre lists and running WLI sessions where possible.

- Outpatient pathways play a lesser part in the drop of performance, the ambition to achieve 100% return to activity has not yet been achieved, current return of activity is around 90% with further recovery limited due to social distancing and running safe services in line with current infection control and clinical guidance. The main focus to increase activity has been use of video and telephone consultations, the national ambition is for a minimum of 25% of all outpatient activity to be non-face to face, with 60% of all follow-up appointment activity being non-face to face. UHD has performed well achieving 42 % of all outpatient activity being non-face to face.

DM01 (Diagnostics report)
Only 1% of patients should wait more than 6 weeks for a diagnostic test

October 20	Total Waiting List	< 6weeks	>6 weeks	Performance
UHD	5930	5350	580	**9.8%**

Factors impacting on standard

Clinical Processing Capacity	Lost capacity during quarter 1 drove the decline in performance however this has been improving exponentially during quarter 2, UHD has achieved the ambition of less than 10% of patients waiting longer than 6 weeks by October. Radiology has excelled this month with all modalities achieving the 1% standard; endoscopy and echo cardiology have also started to recover.

High level actions include:
- Continuation of additional temporary endoscopy capacity on the RBCH site and reviewing all endoscopy activity in the Dorset system to reduce waiting times
- working collaboratively across both sites to standardise and reduce waiting times for cardiology, ultrasound, MRI and CT
- Insourcing to provide additional capacity in radiology. A system of examination exchange is in progress to support a reduction in waits on both sites.
- Sharing capacity across sites to reduce the waiting times in endoscopy and echo cardiology.

Cancer Standards
The Trust is still working towards meeting the 62 Cancer Wait time standard (CWT). This is mainly due to significant increase in referral numbers - a trend across Wessex Cancer Alliance but more so at UHD, the catch up of the diagnostic tests back log that has progressed

	Measure	Target	Quarter 1 2020/21	Sept 20 - FINAL	Q2 20/21 FINAL
UHD	Cancer Plan 62 Day Standard (Tumour)	85%	79.3%	76.1%	80.0%
	62 Day Screening Standard (Tumour)	90%	73.3%	85.7%	73.3%
	31 Day First Treatment (Tumour)	96%	96.2%	60.0%	94.4%
	Subsequent Treatment - Surgery	94%	89.4%	91.2%	86.7%
	Subsequent Treatment - Radiotherapy		98.8%	100.0%	100.0%
	Subsequent Treatment - Anti Cancer Drugs	98%	100.0%	100.0%	100.0%
	Faster Diagnosis	75%	76.3%	72.9%	77.4%
	Over 104 days (treated in month)	N/A	18	9.5	23.5

Performance
The catch up of the diagnostic tests back log that has progressed. Several patients are still having their final treatment after the 62 day date due to capacity issues as a result of the increasing numbers being referred. Clinical teams working across both PH and RBCH sites are working together to take actions to mitigate against this and link with the wider Dorset system. The number of patients over 104 days (backstop position) continues to improve.

Factors impacting on standard

Demand	• Two Week wait referrals continue to increase – in some specialities significantly beyond pre-COVID levels- most noticeably colorectal, gynaecology and breast
Clinical Processing Capacity	• Patient choice continues to impact all pathways • Reduced capacity in interventional areas • Specific challenges in some pathways- due to capacity to manage the increased demand.

High Level Actions ongoing
- Clinical teams working across sites to maximise capacity
- Exploring opportunities for pathway improvements across both Hospital sites –especially focusing on one stop opportunities at the start of the pathway to improve time to diagnosis.
- Enhanced tracking data to proactively manage patients as part of weekly meetings with respective Directorates, identifying 'at risk' patients
- Weekly backlog/backstop meeting to manage patients who have already breached 62 days to ensure on going monitoring and actions
- Use of independent capacity continues
- Actively participating in the Regional Adapt and Adopt programme- focusing on urology
- Participating in the roll out of the Wessex Rapid diagnostic service.

<u>Quality, Safety, & Patient Experience</u>

Infection Control
Following on from last month's report, the background level for cases of Covid-19 in the Bournemouth, Christchurch and Poole Council areas has continued to rise. This higher level of Covid-19 in the population has led to a significant increase in the numbers of patients being admitted to the hospital and critical care.

Within the trust and healthcare partners, procedures are in place to test patients for Covid-19 at a number of points in the hospital pathway in accordance with national guidance. This ensures that cases can be detected early with ongoing surveillance to identify healthcare associated infection. Throughout October however, there has been a rise in the number of asymptomatic patients attending who subsequently test positive on their second swab; these patients are classified as community acquired.

During October the Trust has declared a number of Covid-19 outbreaks on both sites with the most significant being in Older Persons Services on the Poole site. Management of each outbreak has been robustly managed though the daily Outbreak Control Meetings chaired but the Director of Infection Prevention and Control (DIPC) or deputy and attended by representatives Public Health Dorset and Dorset CCG. None of the outbreaks have reached the stage of formal closure; therefore the reports are in process, it is anticipated however that there will be cases of hospital acquired Covid-19.

The trust is continuing to follow strict infection prevention and control guidelines. The trust Infection and Prevention Control Team continue to work to implement and strengthen the response to COVID-19 including advising on the safe working practices, required to implement new national guidance.

Patient Safety: Pressure ulcers
The incidence of hospital acquired pressure ulcers has remained stable and within established parameters (<4%) during October 2020. Deep tissue injuries to patient heels are currently a noted trend that the Tissue Viability Team is focusing on. Work continues with community partners with regards to the noted increased severity of tissue injuries on admission

Patient Safety: Falls
The number of moderate and above incidents remains in line with last year's trajectory. Current issues noted include the ability to provide enhanced care observations for at risk patients and managing challenging behaviours within COVID-19 restrictions (e.g. wandering, confusion).

Patient Experience
The Trust continues to working towards aligning all systems and processes for complaint handling process/reporting.

Visitor Guidance is being constantly reviewed and updated to align with national recommendations and respond compassionately to the needs of our patients and their families.

Workforce

12 month rolling rates to October 2020:

		20/21 YTD	19/20 YTD	Variance
Turnover		10.8%	12.2%	-1.4%
Vacancy Rate		0.8%	5.1%	-4.3%
Sickness Rate		4.2%	4.0%	**0.2%**
Appraisals	Values Based	36.8%	52.7%	**-15.9%**
	Medical & Dental	58.9%	82.1%	**-23.2%**
Statutory and Mandatory Training		87.0%	88.8%	**-1.8%**

Performance

Overall turnover and vacancy rates remain under control with general sickness levels remaining steady.

Covid related absence has increased in some areas due to positive cases, employees in self isolation and on-going shielding for the small group of extremely clinically vulnerable staff. This is not affecting activity.

In relation to statutory and mandatory training levels, urgent work is underway to address the variance across the sites in relation to particularly infection control and the Covid toolkit.

The launch of BEAT VLE with its suite of on-line training will take place as soon as possible for the Poole site – anticipated to be by 4th January. Appraisal levels continue with steady completion.

We continue to address increasing demands for temporary staff via our banks and to work to keep agency spend down which is challenging due to operational pressures – particularly in ED.

The Flu campaign 20/21 is going well with more than 51% of front line staff vaccinated so far.

Factors impacting on standard

Appraisals	Appraisals are lower than a normal year due to Covid but they are continuing with steady completion.

High Level Actions:

- Work continues to refine and interpret the detail of these high level aggregated UHD indicators as we bring different types of systems together.
- The recruitment system TRAC has now merged which will shortly enable us to report against key indicators to better inform actions around vacancies.
- Priority recruitment includes Registered Nurses and Health Care Support Workers, Ward Support Assistants and Housekeepers.
- We are working to align the Trust induction programmes across the sites particularly for Medics and HCSWs.

Covid support:

- We are working very closely with managers in this challenging period including with updating risk assessments, addressing frequently asked questions, HR Helpline and direct support.
- Following risk assessment, clinically vulnerable staff are being supported to work with Covid measures in place to help them stay safe while on sites or where there is suitable work, at home.
- We communicate regularly about the very wide range of Health and Wellbeing interventions and support mechanisms available to our people.

Merger Integration:

- We have now concluded the organisational change for Tier 2 (senior roles immediately under the Chief Officers) and other critical roles.

	• Some Corporate T3 posts are already appointed and others T3 posts across the functions are being fast tracked where appropriate. • 44 appointments have been made so far including 7 interim. • The sequencing of the main Tier 3 operating structure implementation is being planned and coordinated with preparatory work underway to enable a move into consultation/s. **<u>Finance</u>** On the 1 October a new national Financial Framework came into effect with the Trust being allocated a fixed funding envelope. This new framework no longer provides for a retrospective true-up to achieve financial balance. Instead the Trust has submitted a financial plan for the period to 31 March 2021 forecasting a £5.6 million deficit, inclusive of ongoing COVID-19 costs, Phase 3 recovery, and winter preparedness. During October the Trust is £26,000 behind plan reporting a £1.024 million deficit against a planned deficit of £998,000. CIP of £225,000 was achieved in month being £45,000 below target. Year to date capital expenditure at the end of October amounted to £16.9 million against a plan of £27.8 million. This variance reflects the previously reported slippage and the Trust has now formalised a planned £6 million capital underspend as part of the overall Dorset ICS capital envelope. The Trust is currently holding a consolidated cash balance of £123.2 million, however this includes the November contractual payments of £51.8 million received in advance.
Options and decisions required:	No decisions required
Recommendations:	**Members are asked to:** Note the areas of the Board focus for discussion
Next steps:	Work will continue in addressing the actions raised as part of the escalation reports.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Continually improve the **quality of care** so that services are safe, compassionate, timely and responsive – achieving consistently good outcomes and an excellent patient experience To be **a great place to work**, by creating a positive and open culture, and supporting and developing staff across the trust, so that they are able to realise their potential and give of their best To **transform and improve our services** in line with the Dorset ICS Long term Plan, by separating emergency and planned care and integrating our services with those in the community
BAF/Corporate Risk Register: (if applicable)	**UHD 1342** - The inability to provide the appropriate level of services for patients during the COVID-19 outbreak **UHD 1383** - COVID -19 risk relating to HCAI **UHD** (risk ref tbc) – COVID -19 impact on staffing **UHD 1131** – inability to effectively place patients in the right bed at the right time (Flow) **UHD 1387** - Demand for acute inpatient beds will exceed bed capacity

	(Demand & Capacity) **Existing RBCH/Poole site risks (*1011, 801, 1332 – UHD ref no. awaited*)** re ED: *1) Performance; 2) Ambulance handovers; 3) Patient safety* ***Existing RBCH/Poole site risks (1053 – UHD ref no. awaited)*** *re Long Length of Stay / Discharge to Assess* **RBCH – 808** Risks to regulatory performance compliance, patient delay and dissatisfaction if RTT related targets for 2019/20 are not met **PHT - 1074** Risks associated with breaches of 18 week Referral to Treatment and 52 week wait standards
CQC Reference:	All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	**Date**
Trust Board (Full report)	Nov 2020
Quality Committee (Quality)	Nov 2020
Finance & Performance Committee (Operational / Finance Performance)	Nov 2020
Trust Management Group	Nov 2020

Quality - SAFE

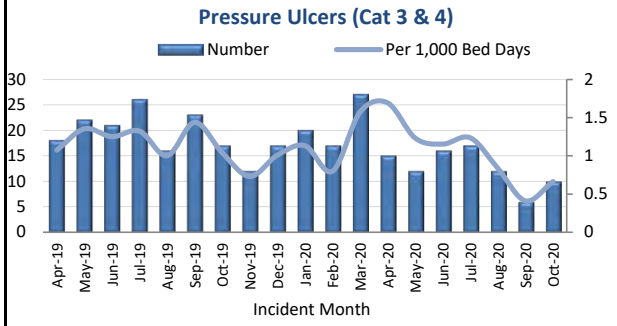
Commentary on high level board position

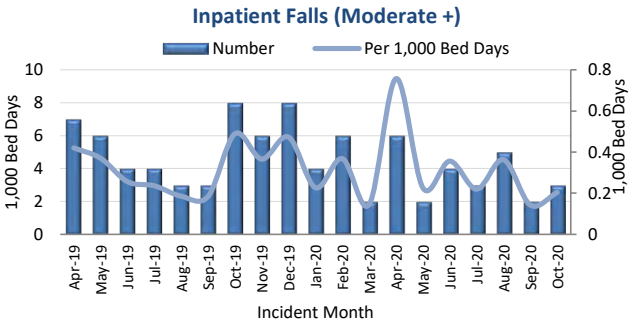
- Four new SI were reported in month (Oct 2020). YTD figure still in line with 2019/20 trajectory.
- No new Never events reported in October, however 2 reported for November 20 (details in SI report to QC and BoD)
- National NRLS reporting figures published (Oct19-March 20), both sites have seen an increased in reporting (no harm and minor harm events) from the previous 12 months. PH reporting rate Oct19-March 20 = 58/1000 bed days (Oct18-March 19 - 46.7). RBCH reporting rate Oct19-March 20 46.5/1000 bed days (Oct 18-March19 - 38.8/1000 bed days). Both sites have a positive reporting culture.

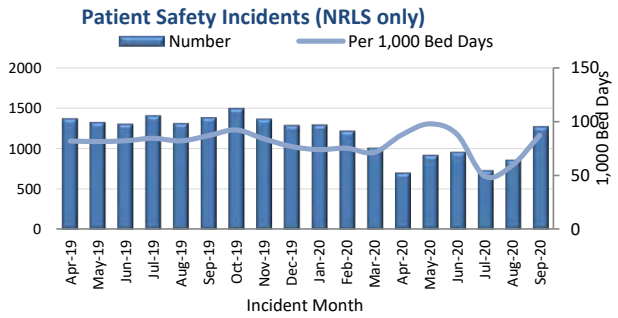
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Presure Ulcers (Cat 3 & 4)	Number	88	143	55
	Per 1,000 Bed Days	0.51	0.63	0.12
Inpatient Falls (Moderate +)	Number	25	35	10
	Per 1,000 Bed Days	0.14	0.15	0.01
Medication Incidents (Moderate +)	Number	11	12	1
	Per 1,000 Bed Days	0.06	0.05	-0.01
Patient Safety Incidents (NRLS only)	Number	5,489	9,661	4172
	Per 1,000 Bed Days	31.53	42.32	10.79
Hospital Acquired Infections	MRSA	0	0	0
	MSSA	20	23	3
	C Diff	38	41	3
	E. coli	37	56	19

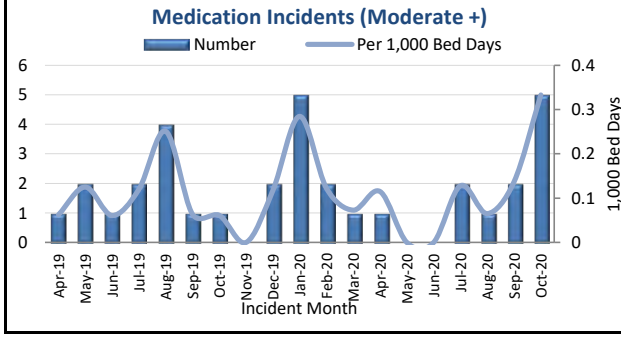
High Level Trust Performance

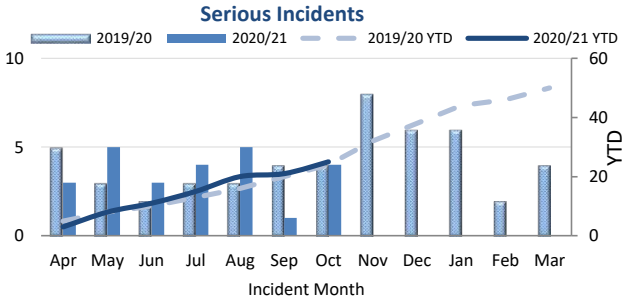


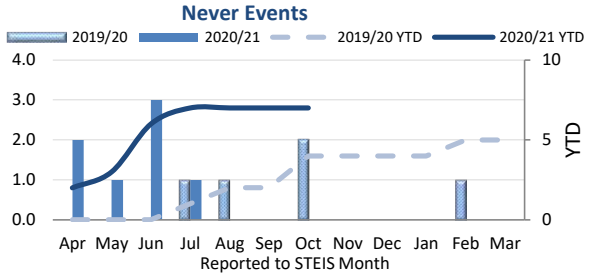




0 (Sept 20) MRSA 0 (Oct 20) | 2 (Sept 20) MSSA 3 (Oct 20) | 7 (Sept 20) C Diff 1 (Oct 20) | 12 (Sept 20) E. coli 4 (Oct 20)







Quality - RESPONSIVE

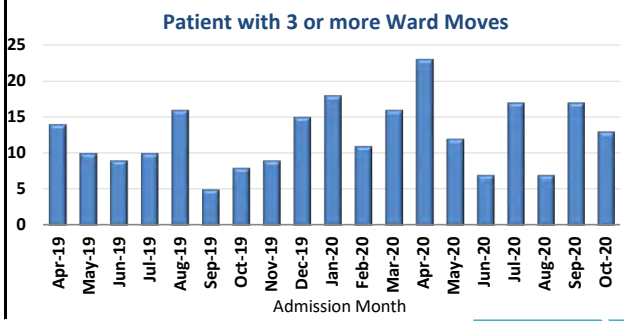
Commentary on high level board position

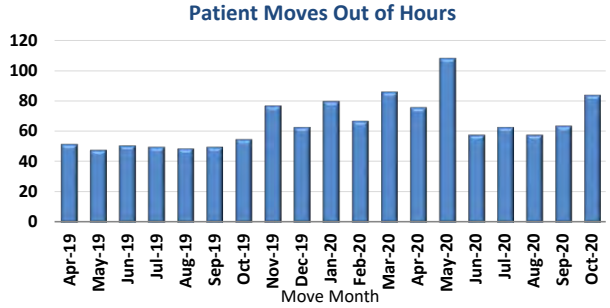
- The National Mixed Sex Accomnodation return has been suspended from April 2020. The Trust however, continues to manages same sex accomodation in the usual way.
- Patient Moves, has been highlighted nationally as a link to nosocomial Covid-19 outbreaks. Work to streamline admission pathways and minimise patient movement cross wards is on-going as part of the Covid pathway work.
- ENA falls, MUST and Waterlow Assessment compliance has shown a consistent improvement from April - October 2020.

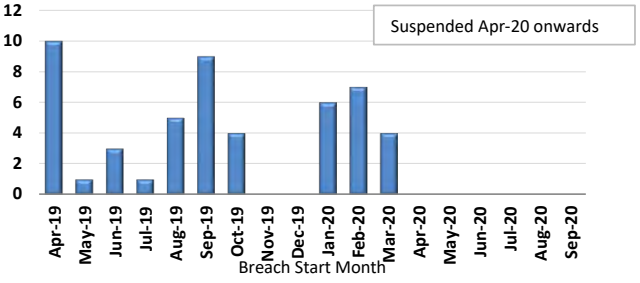
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)		96	72	-24
Patient Moves Out of Hours (Non-Clinically Justified Only)		511	355	-156
Mixed Sex Acc. Breaches Suspended Apr-20 onwards due to Covid		0	33	N/A
ENA Risk Assessment **infection eNA assessme went live at RBCH during April 20*	Falls	61%	51%	10%
	Infection*	72%	15%	N/A
	MUST	64%	54%	10%
	Waterlow	60%	52%	8%

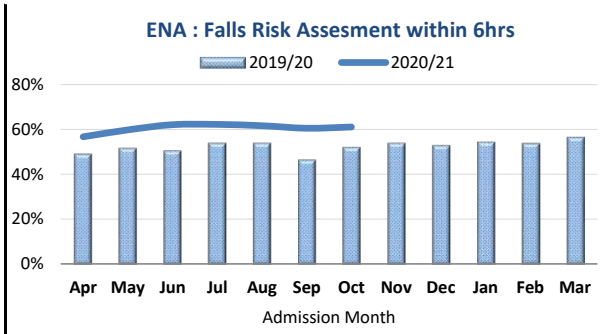
High Level Trust Performance

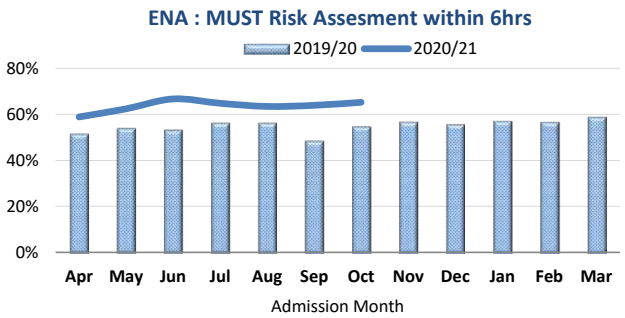


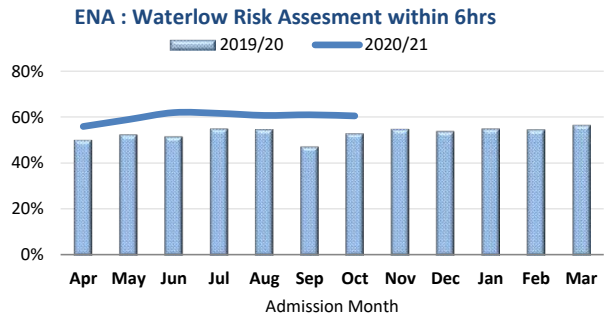




60.5% (Sep 20) Falls 61.1% (Oct 20) | 70.1% (Sep 20) Infection 64.3% (Oct 20) | 64.0% (Sep 20) MUST 65.3% (Oct 20) | 61.0% (Sep 20) Waterlow 60.5% (Oct 20)







Quality - EFFECTIVE AND MORTALITY

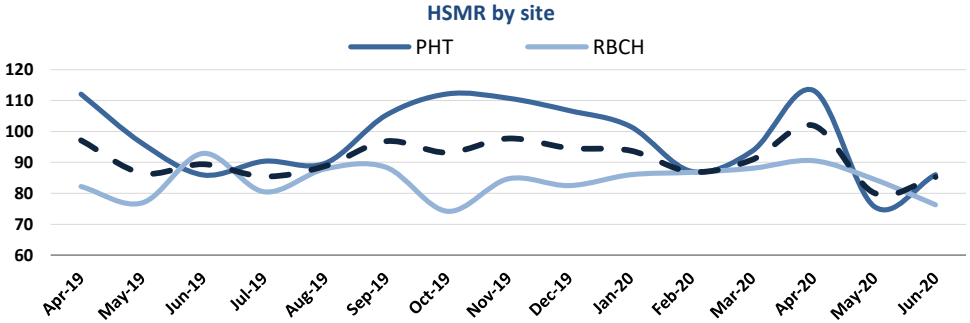
Commentary on high level board position

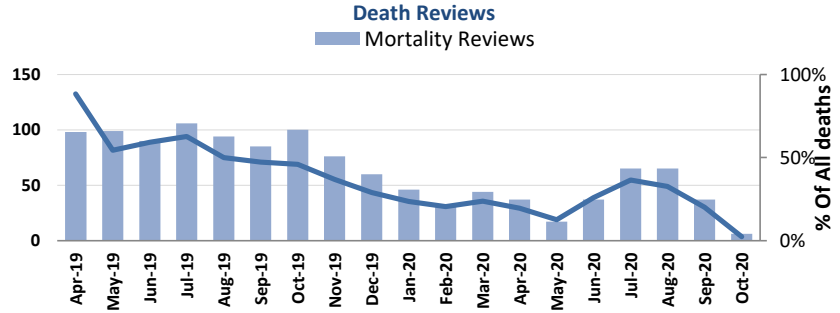
- Medical Examiner reviews continue during Q3.
- Increased implementation at Poole with the ME service now reviewing 95% of all in hospital deaths.
- Pilot of ME review of community hospital deaths as part of CCG collaborative project to start in November 20.

High level Board Performance Indicators

			20/21	19/20	Variance
HSMR	Latest	(Jun 20 - RBH)	76.3	76.9	
	Latest	(Jun 20 - PHT)	86.0	85.9	
Patient Deaths		YTD	1385	1510	**125**
Death Reviews		Number	264	672	**N/A**
Note: 3 month review turnaround tar		Percentage	21%	56%	
Deaths within 36hrs of Admission			241	233	**8**
Deaths within readmission spell			98	155	**-57**
Patient readmitted within 5 days					

High Level Trust Performance

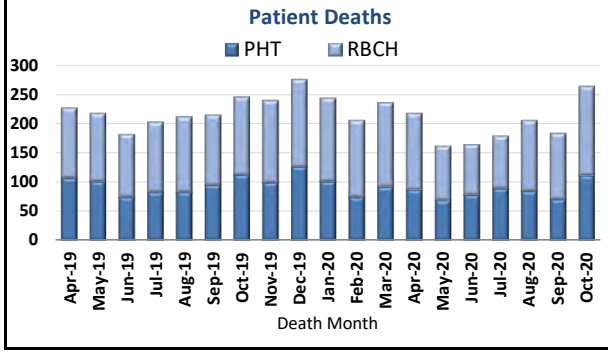


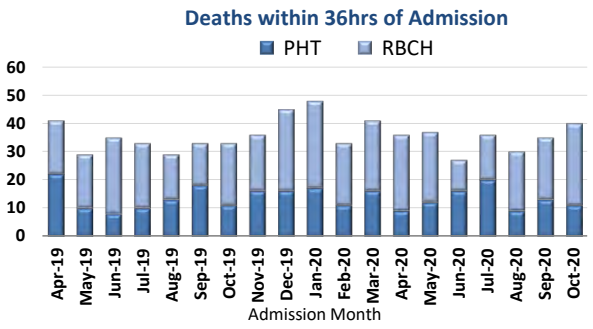


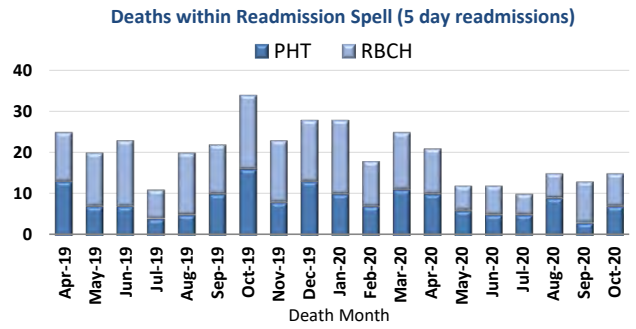
80.1 (May 20) | HSMR | 85.3 (Jun 20)

185 (Sep 20) | Patient Deaths | 265 (Oct 20)

26.0% (Jun 20) | Deaths Reviewed | 37 %(Jul 20)







Quality - CARING

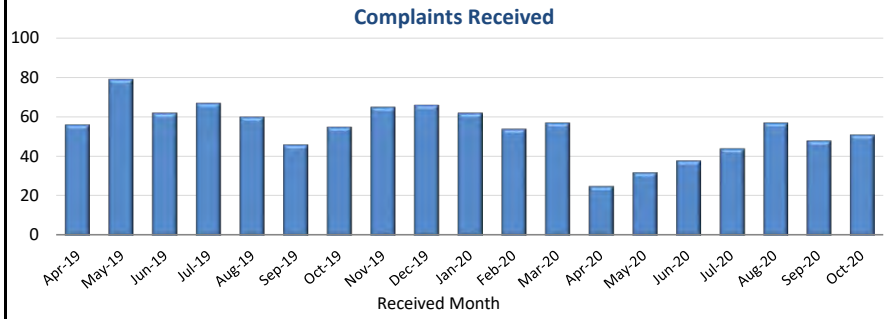
Commentary on high level board position

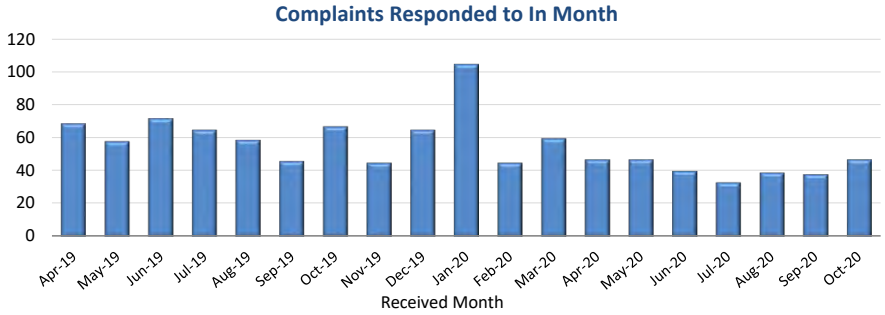
- Trust complaints have risen throughout quarter two which is aligned with the re-start of elective services and increased patient capacty. Currnet numbers of complaints measure equitably against the 2019 data.
- In October 2020 of 51 complaints were received while 47 were responded to in month.
- The national collation of the friends and family test is due to restart in December 2020 (reported in January 2021). Local friends and family test using the new national rating from very good to very poor, shows the Trust with a 90% very good rating in the areas surveyed.
- As part of the proposed national lockdown planned for November 2020 - the Trust has revisited it visitor guidelines to align with the national lockdown guidance.

High level Board Performance Indicators

	20/21 YTD	19/20 YTD	Variance
Complaints Received	295	425	130
Complaint Response Compliance		TBC	
Complaint Response in month	291	436	145
Section 42's	7	17	10
Friends & Family Test	91%	N/A	-
Return changed 20/21			

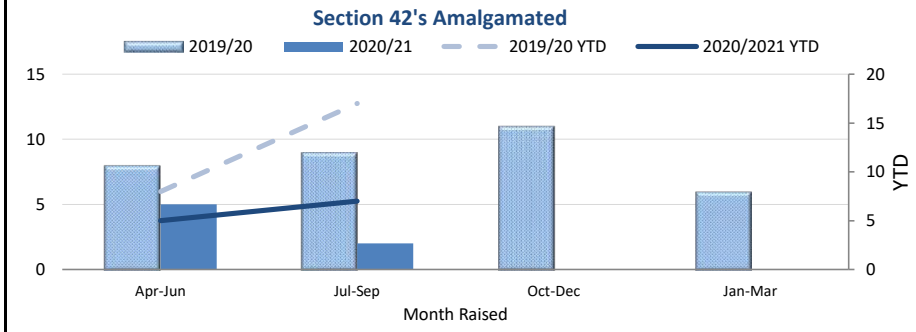
High Level Trust Performance

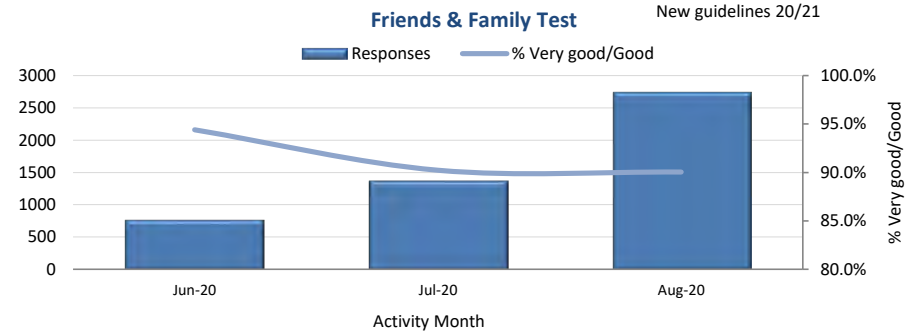




48 (Sep 20) > Complaints Received > 51 (Oct 20)

38 (Sep 20) > Complaint Responses > 47 (Oct 20)





Quality - WELL LED

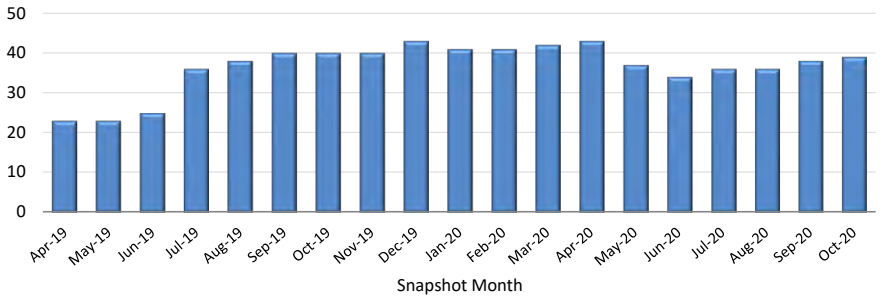
Commentary on high level board position

- Work on the red flag alignment has been superseded by the current pandemic safe staffing for wave-two work; for which new quality metrics are being developed. This work will be pan-UHD bringing the two sites together with one safe staffing framework.
- To note the Bournemouth site only report on red flags that were not mitigated.
- The Trust continues to be well measured against peer organisations for CHPPD. Overall 2020 shows an improvement in CHPPD in comparison to the previous year. The fall in overall CHPPD is linked to the adjusted staffing templates in place in quarter one and two for the pandemic.
- Combined BAF for UHD agreed at Audit Committee and Board of Directors in October 20
- Care Group leads provided details of Poole and RBCH Risk registers at formal handover meetings in September 20. Support being provided by Quality and Risk team to review and amend to ensure fit for purpose for new UHD structures and actitivites.
- Single CAS Alert process for UHD implemented from 1 October 20.

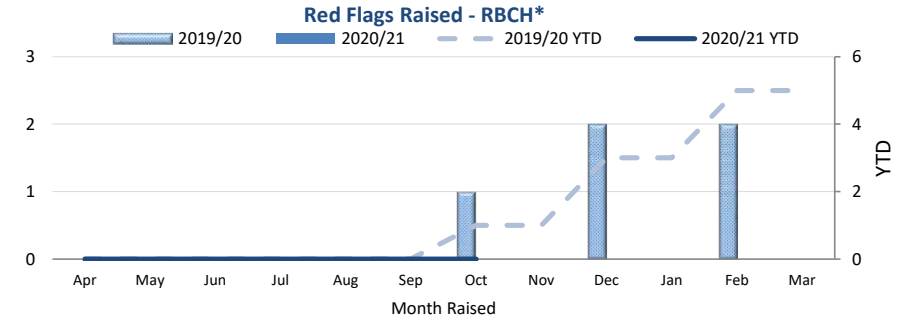
High level Board Performance Indicators

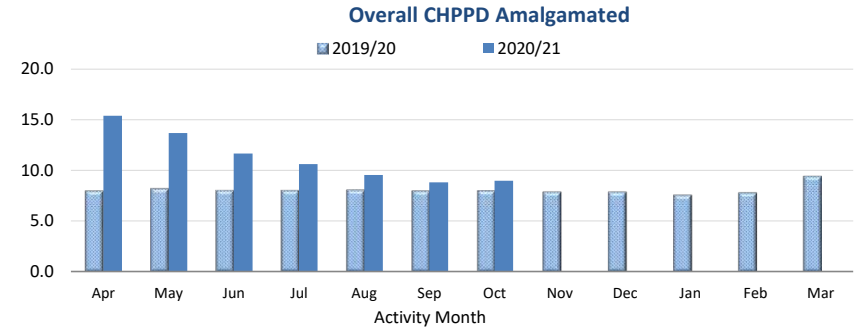
	20/21 YTD	19/20 YTD	Variance
Risks 12 and above on Register	39	40	-1
Red Flags Raised* *different criteria across RBCH & PHT	182	353	-171
Overall CHPPD	10.8	8.0	2.8
Patient Safety Alerts Outstanding	0	0	0

High Level Trust Performance

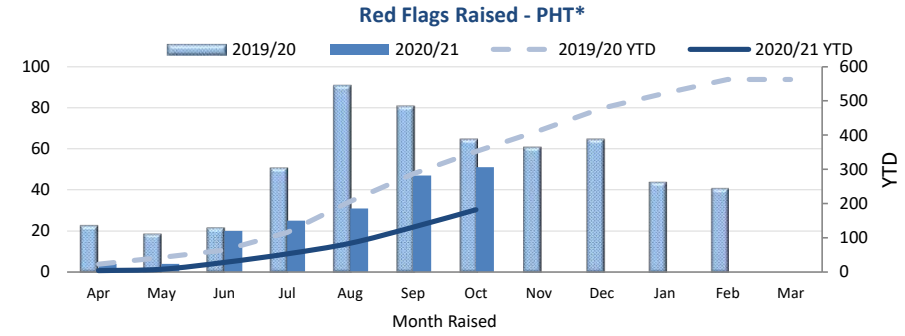


38 (Sep 20) | Risks 12+ | 38 (Oct 20)





8.8 (Sep 20) | Overall CHPPD | 8.9 (Oct 20)



Workforce

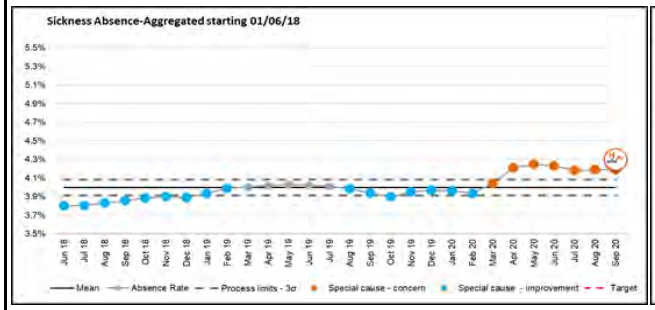
Commentary on high level board position

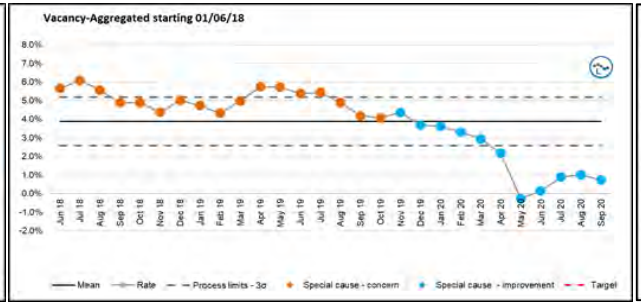
- We continue to work to refine and interpret the detail of these high level aggregated UHD indicators and to double check accuracy as we bring different types of systems together.
- Overall turnover and vacancy rates remain under control and the recruitment system TRAC has now merged which will shortly enable us to report against key indicators to better inform actions around vacancies.
- General sickness levels remain steady. Covid related absence has increased in some areas due to positive cases, employees in self isolation and on-going shielding for the small group of extremely clinically vulnerable staff. This is not affecting activity. Following risk assessment, clinically vulnerable staff are being supported to work with measures in place to help them stay safe while on sites or where there is suitable work, at home.
- We are seeing a marked increase in Statutory and Mandatory training compliance and although lower than usual, appraisal levels continue with steady completion.
- We continue to address increasing demands for temporary staff via our banks and to keep agency spend down which is challenging due to operational pressures – particularly in ED.
- The Flu campaign 20/21 is going very well with more than 51% of front line staff vaccinated so far.

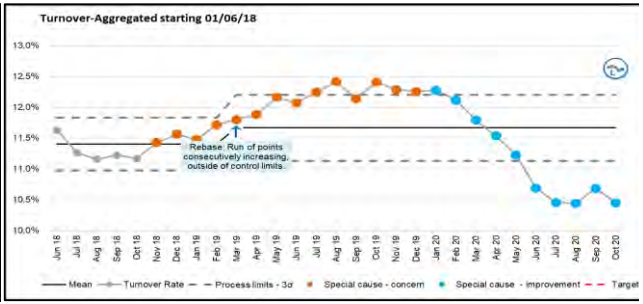
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Turnover		10.8%	12.2%	-1.4%
Vacancy Rate		0.8%	5.1%	-4.3%
Sickness Rate		4.2%	4.0%	0.2%
Appraisals	Values Based	36.8%	52.7%	-15.9%
	Medical & Dental	58.9%	82.1%	-23.2%
Statutory and Mandatory Training		87.0%	88.8%	-1.8%
Staff Friends & Family Test	Caring	N/A	87.4%	
Note: 19/20 Q1 & Q2 only	Work		72.7%	

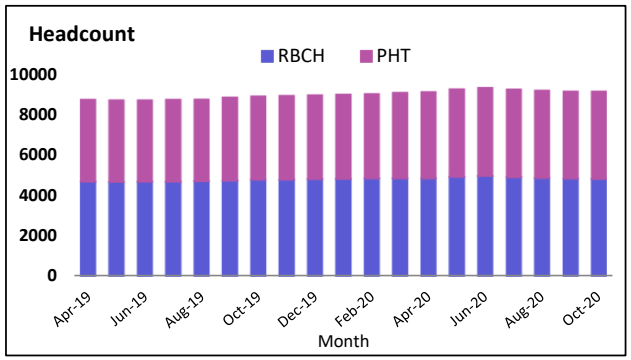
High Level Trust Performance

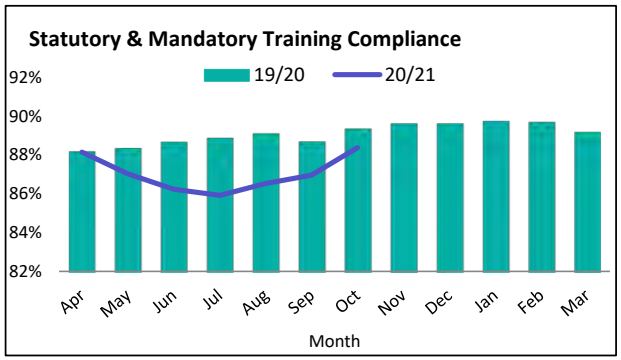


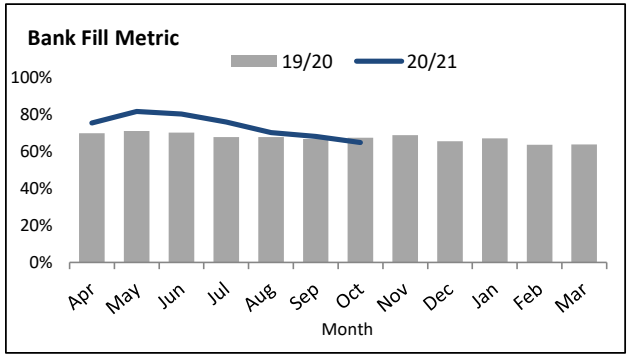




45.9% (Sep 20) | Appraisals (Medical) | 36.8% (Oct 20) | 53.5% (Sep 20) | Appraisals (Values) | 58.9% (Oct 20) | 9.4% (Sep 20) | Turnover | 10.8% (Oct 20) | 4.2% (Aug 20) | Sickness | 4.2% (Sep 20)



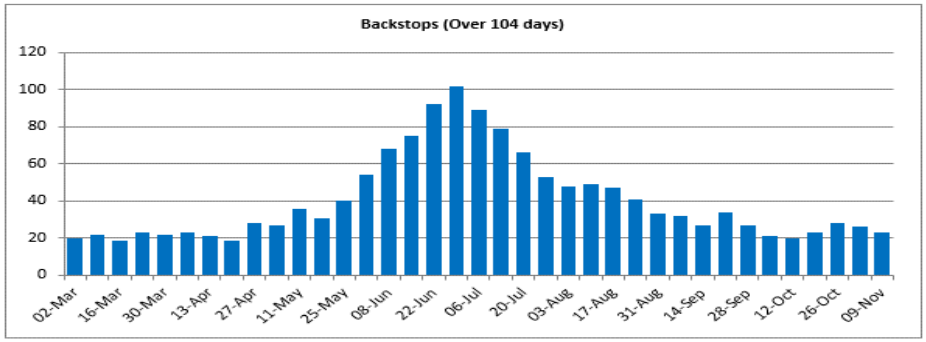


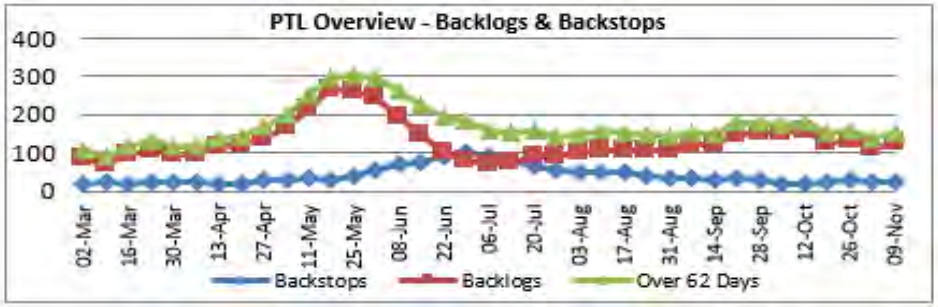


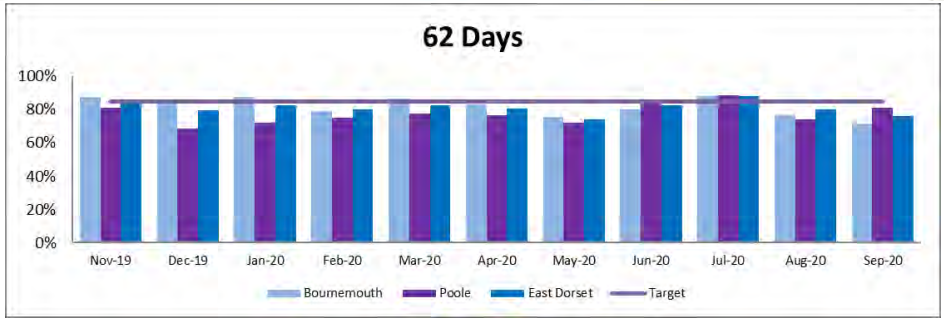
Cancer - Actual September 2020 and Forecast October 2020

Commentary on high level board position

At present the delivery of the cancer standards is being challenged by 2 key factors- increase in 2 week wait demand (755 more this year in Sept/Oct alone), and patients being treated late in the pathway due to Covid for various reasons, meaning they have breached the threshold by the time they are treated. The current active PTL stands at over 3000 (by far the largest in Wessex) a quarter of which are skin patients, 19% colorectal ,14% head and neck, 14% breast. The number of backstop patients continues to fall of the 23 currently reported 8 have a diagnosis, 15 are still awaiting a diagnosis. The backlog also continues to decrease with the exception of skin, colorectal and breast which correlates to the surge in referrals. All actions are being taken to

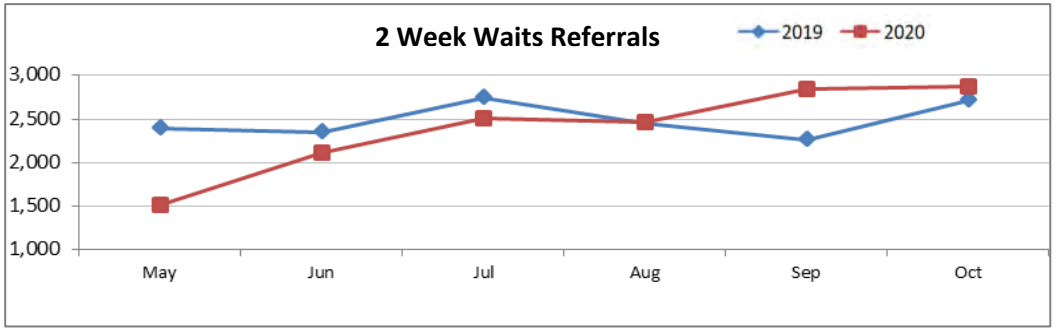






High level Board Performance Indicators & Benchmarking

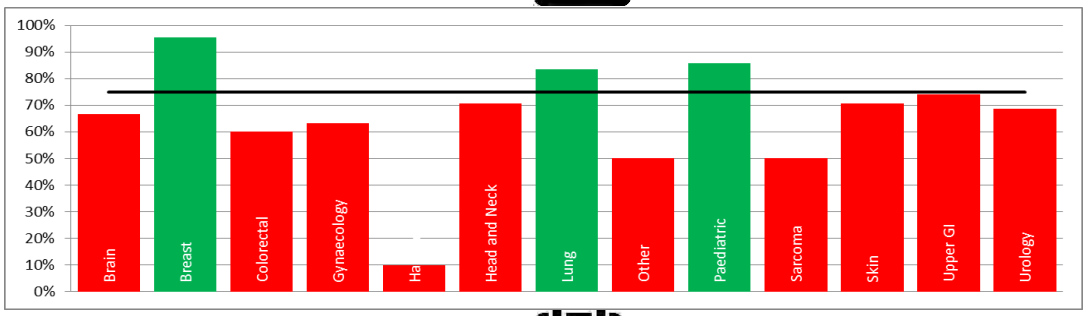
Cancer Standards	Standard	UHD Sep-20	Predicted Oct-20
31 day standard	96%	94.4%	95.7%
62 day standard	85%	76.1%	69.2%
28 day faster diagnosis standard	75%	72.9%	74.6%



Target 75%

28

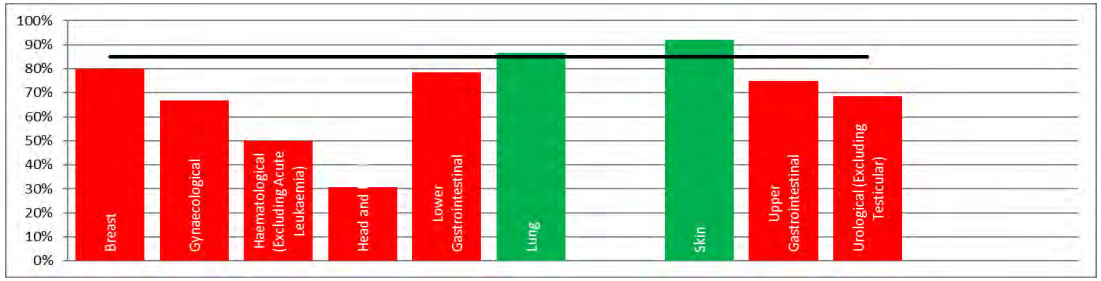
Merged Trust: Sep 2020: 72.9%



Target 85%

62

Merged Trust: Sep 2020: 76.1%



Emergency

Commentary on high level board position

Both Emergency Departments have experienced reductions in attendances with 465 less patients presenting in October over the previous month. Overall attendances remain lower than the same period last year, by an average of 60 per day (combined). Emergency admissions are significantly lower than last year, with c600 less patients admitted in October 2020 when compared to October 2019 with reductions predominantly in the Poole site.

Overall ambulance conveyances increased on September, but are consistent with October 2019. The Trust has refreshed work on Ambulance handovers and has an executive meeting with commissioners in Early November to review the recovery plan and agree future monitoring.

Capital works are due to commence imminently in both departments following successful national bids to support infection control, same day emergency care and ambulance flow and handovers.

The Bournemouth site have moved to the pilot metrics that have been piloted at the Poole site since May 2019. We have asked NHSE/I to confirm the future metrics that will be used in emergency care, and await definitive guidance. In the meantime we have established and are embedding the governance framework for Urgent and Emergency Care improvement and performance reporting.

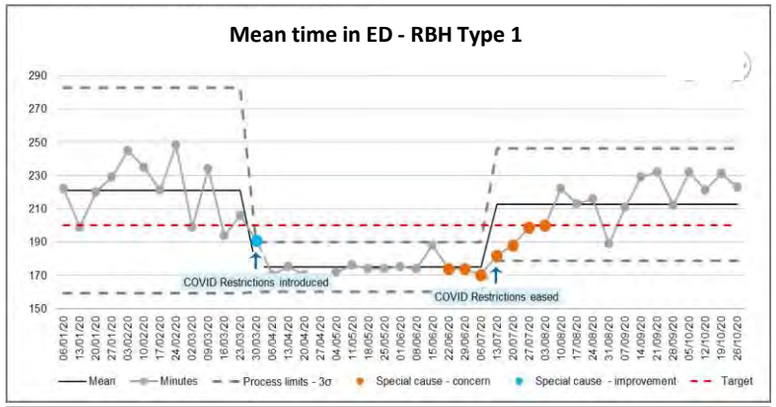
High level Board Performance Indicators

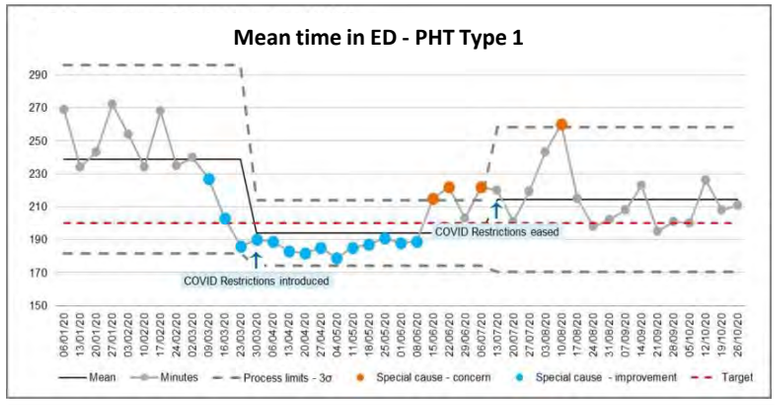
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	5
Clinician seen <60 mins		4664
PHT Mean time in ED	200	210
RBCH Mean Time in ED	200	226
Patients >12hrs from DTA to admission	0	0
Patients >6hrs in dept		1540
ED attendance Growth (YTD)		-15.7%
Ambulance Handover		
Ambulance handover growth (YTD)		-6.7%
Ambulance handover 30-60mins breaches		249
Ambulance handover >60mins breaches		48
Emergency Admissions		
Emergency admissions growth (YTD, all types)		-12.1%

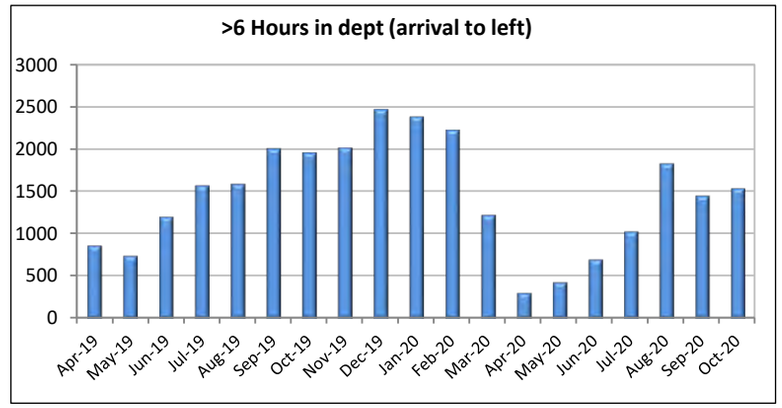
212 mins Sep-20 | Mean time to initial assessment | 219 mins Oct-20

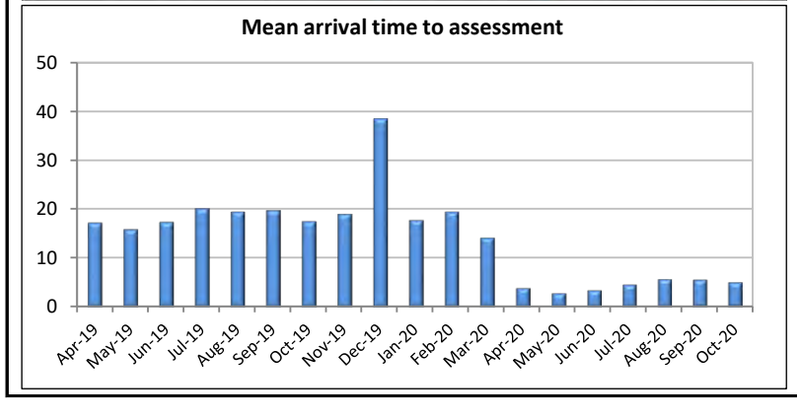
212 mins Sep-20 | Mean time in Dept. UHD | 219 mins Oct-20

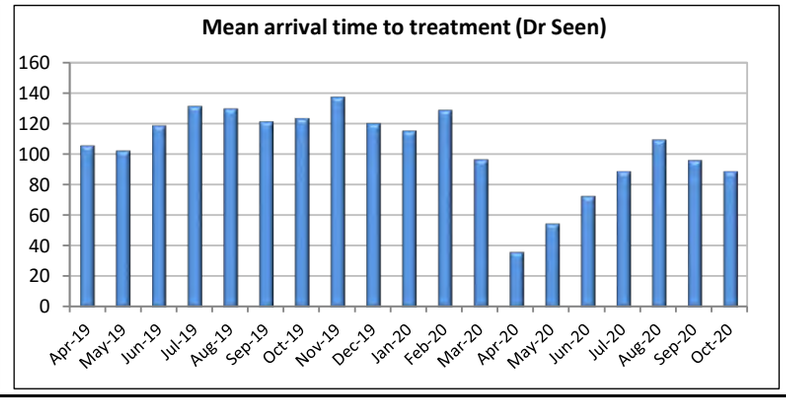
High Level Trust Performance

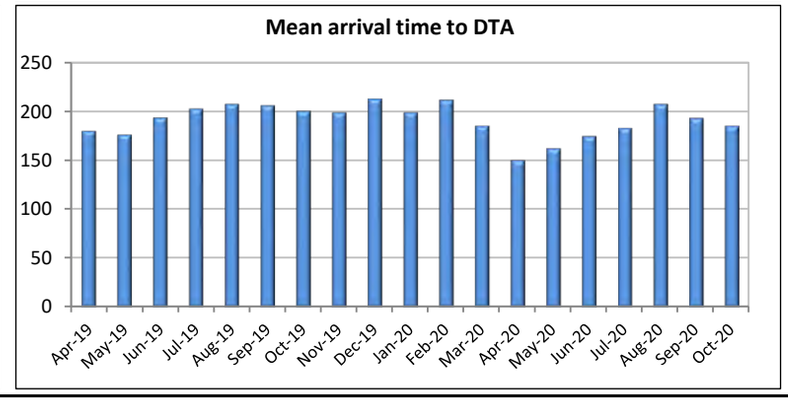












Elective & Theatres

Commentary on high level board position

18 Weeks Referral to Treatment

- The Trust's 18 week RTT performance is 60.4% against the 92% standard, this is due to cancelling elective work in line with national guidance. Constrained capacity due to COVID and the impact of infection control guidance has reduced efficiency.
- The 52+ and 26+ week backlog has increased since last month.
- The Trust number of incomplete pathways is above the March 2019 target.(4%).
- Specialty level recovery plans have been developed and discussed jointly with a focus on system wide working in relation to 52 week waiters. This will not deliver the RTT standard in the short to medium term due to reduced capacity as a result of efficiency and utilisation limitations. Additional capacity plans have been proposed via the Adopt and Adapt initiative (and bids)
- At the end of October 2020 the Trust reported 2,998 52 week breaches. Dorset wide leads are progressing joint plans in 5 key specialties: Endoscopy, Ophthalmology, Orthopaedics and ENT/Oral Surgery. Focus for improvement in November is to reduce the number of 52 week breaches on the non admitted pathway.

Theatre utilisation

- The current theatre utilisation rates are low as they do not include activity undertaken within the Independent Sector and therefore is not a true reflection of the position. The activity undertaken at the acute trusts will be focused on cancer and emergency cases which can also impact adversely on utilisation rates.

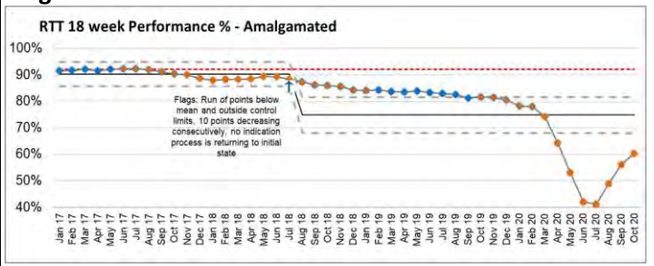
Trauma

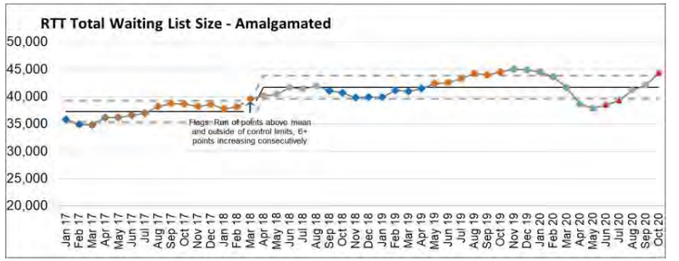
- Hip fractures within 36 hours of admission (clinically appropriate for surgery) is currently 50% .

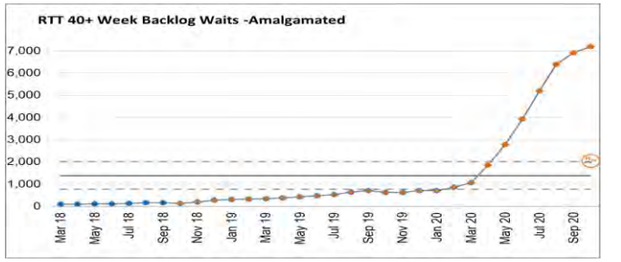
High level Board Performance Indicators & Benchmarking

	Standard	Merged Trust
Referral To Treatment		
18 week performance %	92%	60.4%
Waiting list size	42,587	44,320
Waiting List size variance compared to Mar 19 %	0%	4.1%
No. patients waiting 26+ weeks		14,220
No. patients waiting 40+ weeks		7,197
No. patients waiting 52+ weeks	0	2,998
No. patients waiting 78+ weeks		92
Average Wait weeks	8.5	19.5
Theatre metrics		
Theatre utilisation - main	98%	71%
Theatre utilisation - DC	91%	59%
NOFs (Within 36hrs of being clinically fit - CCG)	95%	50%

High Level Trust Performance

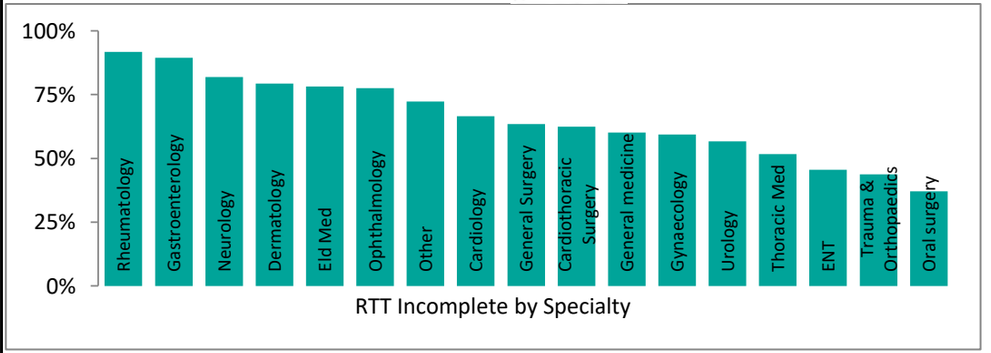


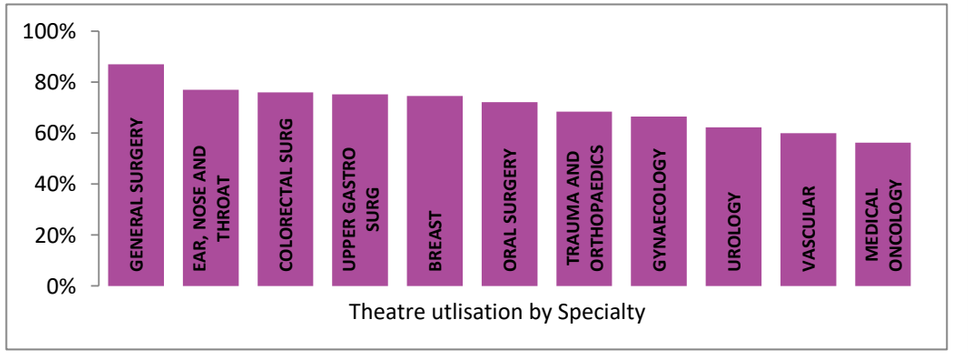




RTT Incomplete 60.4% <18weeks (Last month 56%) Target 92%

Theatre Utilisation 69% (Last month 71%)





Referral to Treatment (RTT)

What is driving under performance?	What actions have been taken to improve performance ?

92% of all patient should be seen and treated within 18 weeks of referral.
Performance 60.4% of all patients were seen and treated within 18 weeks at the close of October 2020.
The overall waiting list (denominator) was **44,320** which is now above the March 19 waiting list of 42,587.

At the end of October 2020, 2,998 patient pathways were reported as having exceeded 52 weeks.

October 2020 compared to January 2020

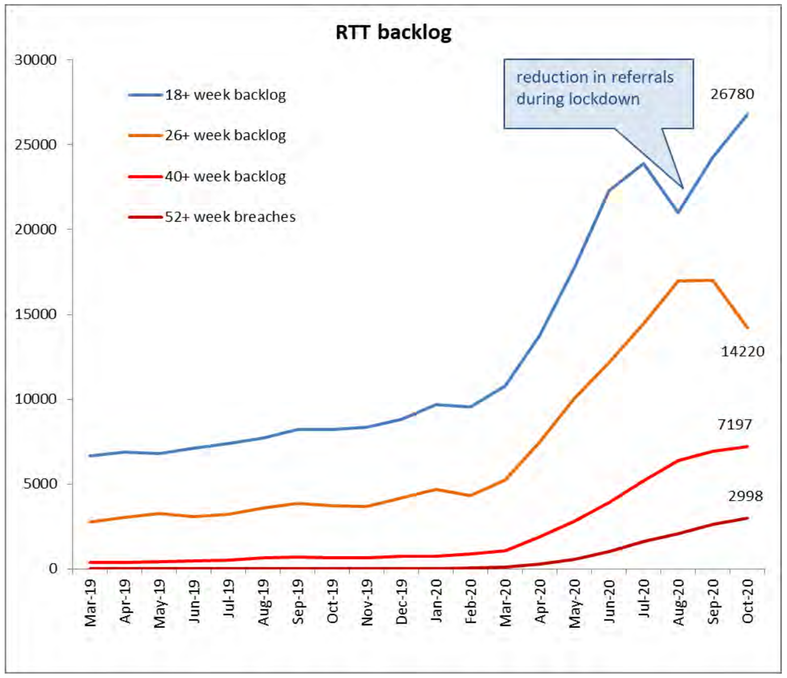
26,770 increase > 18 weeks
14,220 decrease > 26 weeks
7,197 increase > 40 weeks
2,998 increase > 52weeks

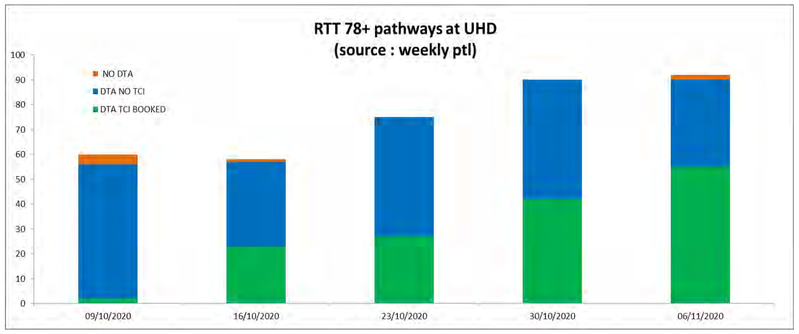
From October all trusts are required to provide patient level exception reports for all patients waiting > 78 weeks.

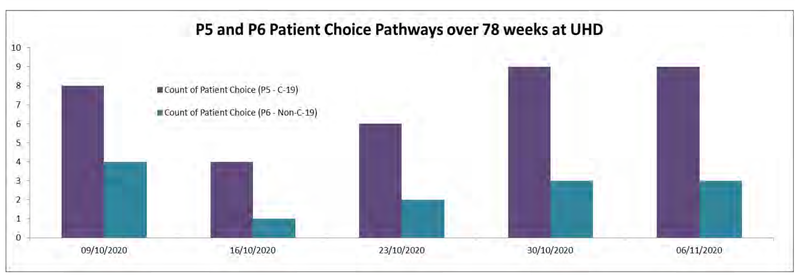
During the first wave of the Covid-19 pandemic the priority was to undertake essential emergency/urgent services whilst adhering to national guidelines on social/physical distancing, shielding and self isolation. This led to a significant reduction in elective activity including out patient appointments which were managed as digital non face to face, whilst this continues the specialties are also recovering by seeing patients face to face where necessary.

Non admitted and Admitted Performance
In addition to the above further reasons for under performance in 18 week patient pathways are:

- Royal College guidelines on the numbers of patients that can be safely seen during Covid leading to many patients being deferred for both outpatients and elective surgery
- Patients chosing not to attend hospital due to concerns about Covid, this number is increasing as prevalence of COVID-19 in the community has increased.
- National requirements regarding testing, PPE and infection control processes restrict a full recovery of activity over the coming months.
-Clinical prioritisation of cancer pathways during period of reduced capaciy / activity







Additional theatre and treatment capacity contiues to be provided by the Indpendent Sector. Close working with colleagues in the Independent Sector continues as it is essential that this capacity is fully utilised.

Endoscopy remains a key priroity with all urgent and Fast Track patients across both Bournemouth and Poole booked first and existing capacity across both sites is being used optimally. The use of the Independent Sector and insourcing has created additional capacity and the use of day theatres on the Royal Bournemouth site is also contributing to an increase in activity levels.

An Operational Performance, Assurance and Delivery programme will be launched in October to oversee improvements in performance, activity and reducign patients with a long wiaign time for treatment.

All patients on an admitted pathway have been cliinically reviewed and prioritised in accordance with the national protocol.

Waiting lists are being merged into one to enable easier management of treating our longest waiting patients in order.

Executive Lead	Mark Mould	Trustwide Lead	Author

Escalation Report

Oct-20

Trauma Orthopaedics -26% compliance achieved against fractured neck of femur target of 95% of clinically appropriate patients to surgery within 36hrs.

Activity | Response

Definition of Trauma Quality Targets & Compliance Achieved

NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission
October 2020 Compliance: 26%

CCG 2018-19 Quality Target: 95% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission or of being clinically appropriate for surgery, increasing to 95% by March 2019 (internal target remains at 95% on a monthly basis)
October 2020 Compliance: 50%
Internal Target: 95% of other trauma patients to theatre within 48 hours of admission or being deemed fit for surgery.
October 2020 Compliance: 90%

Breakdown of Breach Reasons and Waiting Times

NoF Breach Reasons	No. of pts
Patients not fit pre-op & needed optimising	11
Patients on anti coagulants	5
Other NoF patients prioritised	40
Awaiting specialist Blood	1
Awaiting specialist surgeon	1
Total breached NoFs	58

Demand on Trauma Directorate during October 2020

Escalation Activity in October

The service admitted 430 trauma patients in total in October which includes 79 patients with # NOF, 1 patient was transferred pre-operatively to DCH for dialysis and surgery. Fifty eight # NoF patients breached their 36 hour target due to other trauma cases being clinically prioritised, # NoF patients who had been admitted prior to them, and the number of # NoF's. Surge activity where we had high numbers admitted in a 24 hour period also impacts on our ability in achieving our 36 hour target, as on several occasions in October we had 4 or more admitted in a day.
Four patients had THR's for their # NOF and two patients had a revision THR for periprosthetic fractures. There were 22 patients requiring 2 or more trips to theatre, equating to an additional 49 theatre visits, which is approximately 16 theatre sessions (of multiple trips to theatre) if 3 soft tissue cases are done on a session.

Mitigations and Reset

Application of national clinical guidelines: Major trauma, #NOF, Spinal, discharge, flow.
Front door support: 7 day SHO front door cover with mid grade support
Theatre efficiency: as a result of following national guidelines = max 3 cases per session
Fracture clinic capacity increased to 550 per week, all patients are reviewed and receive telephone consultations where appropriate
VFC capacity increased to provide same day access.
RTT Performance 92%. Complete PTL validation and clinical review complete
Bed base, reduction in core capacity to provide critical care capacity, purple and green
Medical cover: continued ward SHO and support of medical SHO cover, established shadow consultant on call rota with escalation plan to include fellows and senior registrars.
SHO recruitment successful with all SHO positions now in post.

No decrease in the average daily NOF admissions leading to backlog of patients awaiting surgery
"other" trauma admissions initially reduced by 70% now on the increase
Conservative treatment options considered before operative intervention, Eg application of bone stimulators with 100% success rate.
Availability of timely fracture clinic reviews, both F2F and telephone
Direct support for front door teams reducing admissions.
Business case for 2 additional conultant posts approved at september HEG, interviews planned for beginning of December.

Complexity of Case Load

Soft Tissue	No. of pts
Patients requiring returns to theatre	22
Additional theatre slots required	49
Complex Surgery	No. of pts
Total Hip Replacements for NoFs	4
Revisions carried out	2

The trauma service started the month in stage 1 of escalation with 30 patients awaiting surgery, we quickly escalated to stage 2 with the greatest number of patients waiting being 45. The majority of October (other than 7 days in stage 1) was spent in stage 3. The third list running at the weekend has greatly reduced the pre-op wait and brought us under control for the beginning of November.
RBH continue to take some of our more suitable patients, which continues to be a support tthe trauma service.
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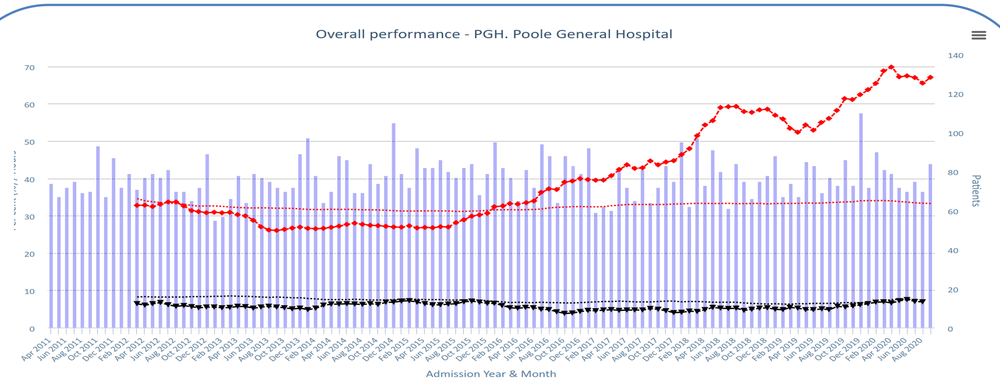
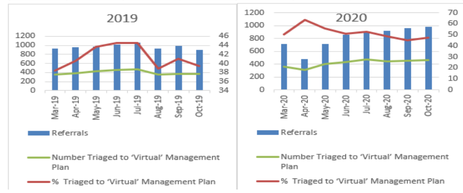
Neck of Femur QSPC Focus



Name	Code	Number of cases submitted	Surgery on day of, or day after, admission	Surgery supervised by consultant surgeon and anaesthetist	General anaesthetic	General anaesthetic and nerve block (of all GA)	Spinal anaesthetic	Spinal anaesthetic and nerve block (of all SA)	Proportion of arthroplasties which are cemented	Eligible displaced intracapsular fractures treated with THR	Intertrochanteric fractures (excl. reverse oblique) treated with SHS	Subtrochanteric fractures treated with an IM nail
Poole General Hospital	PGH	952	24.3	15.8	90.2	47.6	9.4	18.4	97.1	32.9	55.0	92.6
Royal Victoria Hospital	RVB	931	9.5	99.7	18.7	8.9	81.0	0.3	100.0	33.9	45.8	80.0
Leicester Royal Infirmary	LER	906	69.9	61.4	52.1	83.7	48.4	57.4	100.0	17.1	86.3	90.9

October Update on virtual fracture clinic

	2019				2020			
Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan	Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Mar-19	924	38.4	355	Mar-20	716	50.4	361
Apr-19	953	40.6	387	Apr-20	484	63.6	308
May-19	972	43.7	425	May-20	716	55.9	400
Jun-19	1012	44.6	451	Jun-20	861	50.8	438
Jul-19	1064	44.6	467	Jul-20	908	52.6	473
Aug-19	926	38.9	352	Aug-20	922	48.6	448
Sep-19	988	41.1	375	Sep-20	964	45.2	452
Oct-19	899	39.4	365	Oct-20	978	47.2	467



In comparison to 2019 activity we have seen an increase in patients managed vitually, with up to 64% of all referrals managed as such. over the comparable months there has been an over all increase to 55% Vs 40% in 2019. this has undoubtably helped to mitigate demands on F2F fracture clinics and remains a

Author John West

Patient Flow

Commentary on high level board position

Patient Flow

The trend of total monthly admissions exceeding discharges ceased in October, resulting in a favourable net loss of 60 patients (compared to a net gain of 60 patients in September) .

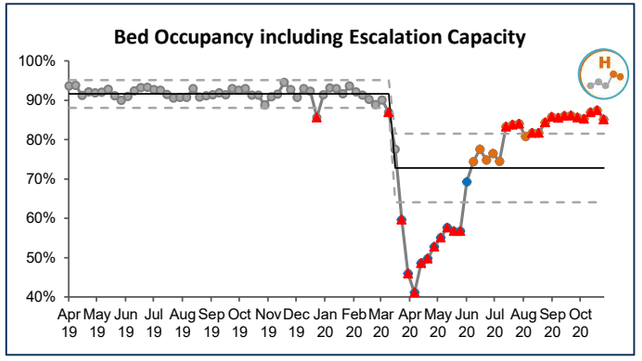
The number of beds consumed by patients with a length of stay great than 7 days has increased for the 6th consecutive month. An average of 182 beds a day in April, increasing to 394 a day in October (+212 Beds|+116%). Bed consumption by patients with a length of stay of over 21 days follows a similar trend (average of 153 beds a day in October compared to 51 in April). However, 153 per day is lower (-18%) of the 186 observed in the first 2 months of the calendar year.

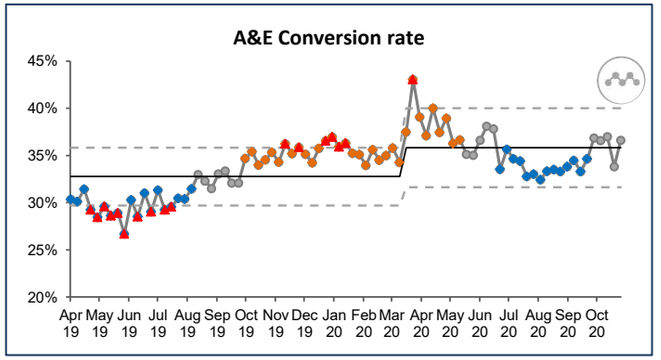
Despite a favourable discharge to admission ratio, the increasing number of patients staying over 7 & 21 days, coupled with reduced bed capacity (for infection control and social distancing measures) has resulted in a sustained bed occupancy rate of >85% (86.0% in October). However this reamins below the 91.7% observed in October last year.

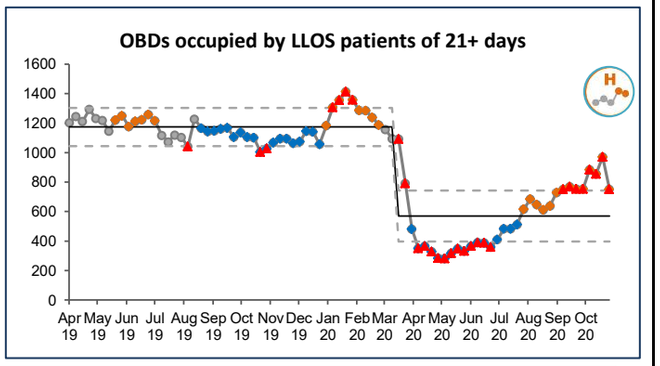
High level Board Performance Indicators & Benchmarking

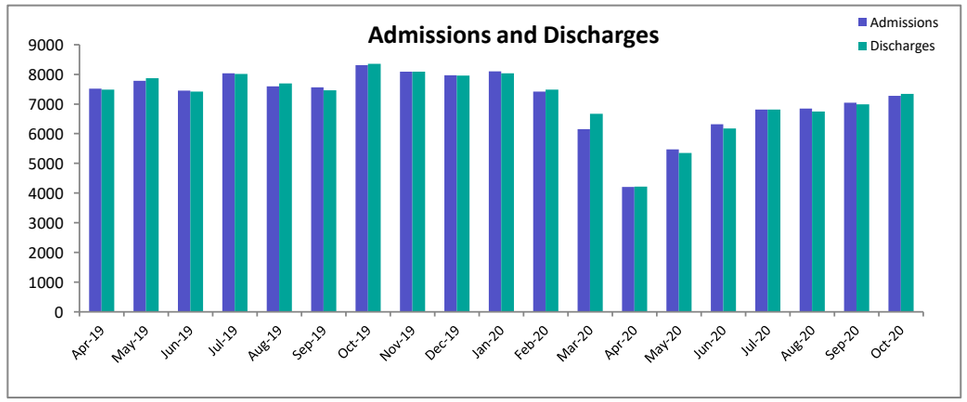
October 2020 Patient Flow	Standard		Merged Trust
Bed Occupancy	85%		86.0%
Stranded patients:			
Length of stay 7 days		*42%*	394
Length of stay 14 days		*21%*	214
Length of stay 21 days	108	*12%*	126
Non-elective admissions			6,279
> 1 day non-elective admissions			3,932
Same Day Emergency Care (SDEC)			2,346
Conversion rate (admitted from ED)	30%		36.1%

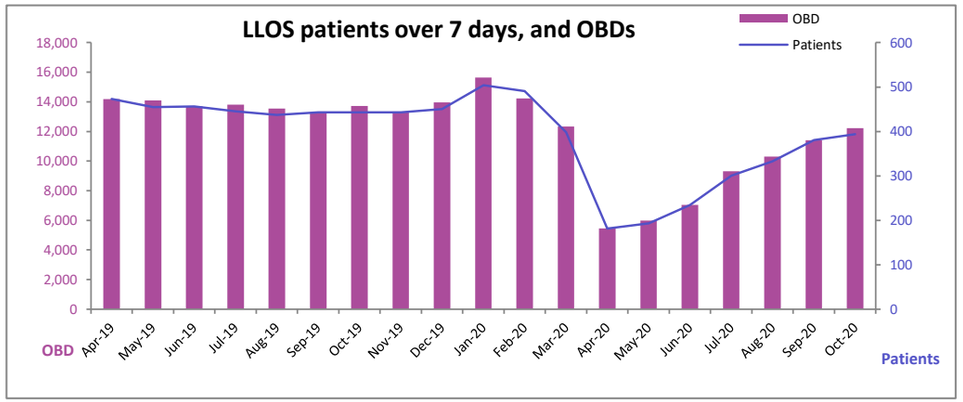
High Level Trust Performance (weekly)











Exception Report

October 20

OCCUPANCY

What is driving occupancy?

Despite a favourable discharge to admission ratio, the increasing number of patients staying over 7 & 21 days, coupled with reduced bed capacity (for infection control/social distancing measures) has resulted in a sustained bed occupancy rate of >85% (86.0% in October). However, this remains below the 91.7% observed in October last year.

Challenges

- Discharge guidance requires Covid negative swabs for patients leaving for care homes, despite PHE guidance indicating viral load can influence a swab result for 90 days. This is having an impact on both acute and community beds.
- Waiting list for community beds.
- COVID related closures at community hospitals impacting community bed capacity and ability to admit.
- Caution and anxiety across the care home sector; and increasing demand for patient swabbing and test results to be available prior to discharge, continuing to impact outflow from the Trust.
- Community beds have a dependancy on availability of care homes, domiciliary care hours etc, increasing the occupancy across the bed base which in turn is impacting outlflow.
- Domicilary Care struggling to meet demand including support to COVID+ patients who remain within acute and community beds.
- The number of care hours needed to support patients post - COVID is significantly higher than non - COVID patients due to the infection control measures needing to be in place.
- End of Life pathways are challenged by a lack of capacity. Marie Curie commissioned to provide additonal support but capacity is now full.
- Patients who are dependant on intermediate care schemes.

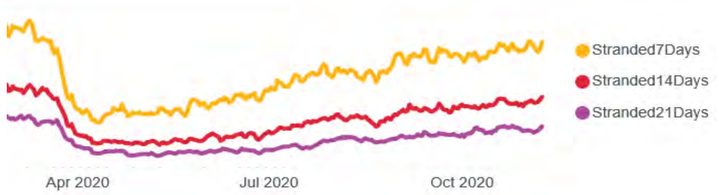
Governance

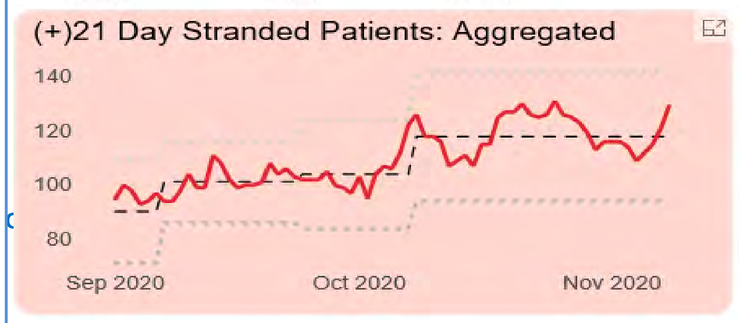
Home First Board with Executive sponsorship and leadership established to oversee the implementation of the D2A model.

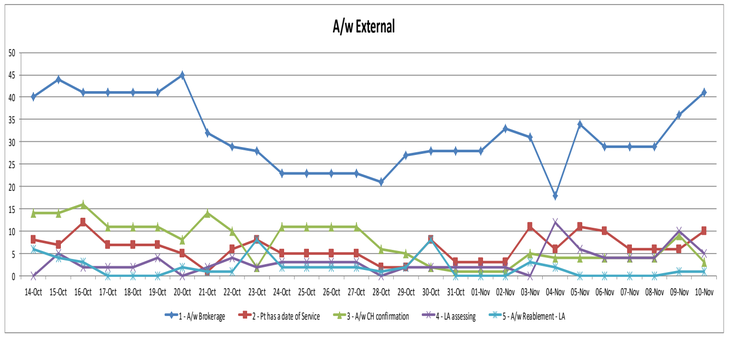
Delivery

A deliver group reporting to the board has been established to design and implement the future D2A model.

Five separate workstreams in place reporting and accountable to the delivery board. Reporting internally to Operational Performance Group.







Actions Taken

Improvement Actions

D2A 'Home First' Model
- Complete review of all processes identified several bottlenecks. Action taken to reduce the number of patients being referred through an MDT process and to brokerage. Some improvement noted during October 2020 for patients awaiting brokerage.
- Additional programme expertise and resource enlisted to support the programme.
- Lead for the Single Point of Access (SPA) appointed.

System Support
- Commissioning proposal to increase the number of care home beds (49). A lead time is expected but will increase capacity to support non - COVID patients leaving acute and community beds for acute discharges/admission avoidance.
- Additional 100 care hours per week being secured.
- Operational group in place to oversee the reduction of the number of patients who no longer meet the critieria to reside within an acute Trust.
- Learning from other systems played back to the Dorset system, including Hampshire.
- ECIST are supporting the Dorset system in the implmentation of the new model. This includes some specific work with acute trusts around Critieria to Reside and 'Same Day Emergency Care,' (SDEC).
- CCG looking at commissioning support from an additonal End of Life care provider. Awaiting firm plan.
- Local Authorities working to free up intermediate care and bridging schemes to support system wide flow.
- Approval from Dorset Silver to progress commissioning of additional community hospital beds.
- Seeking PHE advice regarding 90 day viral load.

D2A Pathway 1
- Partners to provide visible capacity of homecare across the system to "blend" capacity of packages to expedite discharge arrangements for patients returning home.
- Demand & Capacity Review of dom care by social care following reduction of bridging capacity.

D2A Pathway 2
- Urgent commissioning of appropriate D2A block-booked residential and nursing home beds - to ensure patients are discharged rapidly to an appropriate care setting, providing high quality care and ability to manage high turnover of patients from NHS settings.

D2A Pathway 3
- Urgent review of assessment and brokerage process for patients with complex health needs (previously CHC pathway) ensuring D2A is followed and appropriate nursing home beds available across Dorset.

A UHD implementation board has been established to oversee the delivery of internal changes needed to support the new model. These workstreams include Board rounds, Critieria to Reside and

Lead Director Mark Mould

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

- DNA rates increasing, some feedback that patients are more cautious about attending face to face appointments again, also increase in DNA of telephone appointments believed to be caused by new hospital telephone number and patients not recognising it.
- Communications have gone out, but some patients do not answer unidentified numbers.

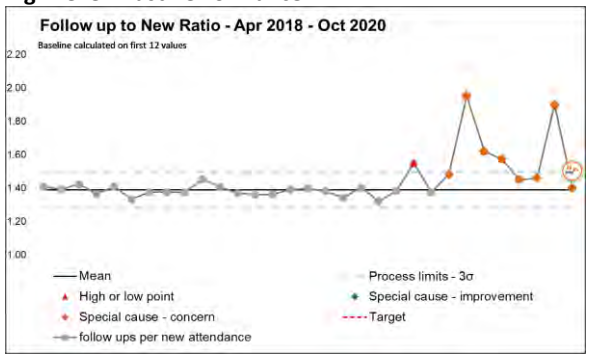
Diagnostics

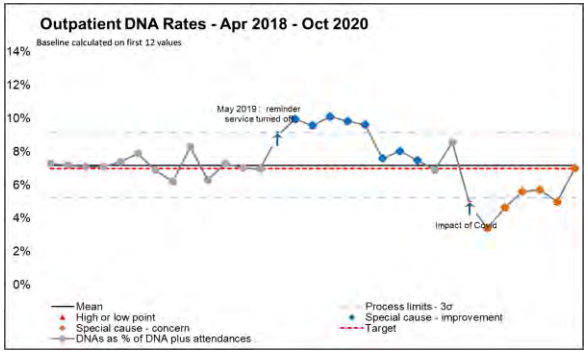
- 90.2% of all diagnostics tests were achieved within the required 6 weeks, of which Radiology achieved 99%
- Endoscopy and imaging capacity constrained by Infection Control requirements . Endoscopy 84.7% within 6 weeks, with the Cystoscopy element increasing from 46.5% to 57%.
- Consolidation of Endoscopy IT systems begun - moving to single waiting list
- Cardiac echo recovery plan constrained by availability of insourcing solution, and process of transfer to PH from RBH. Currently achieving 59.1% within 6 weeks in the DM01 99% standard.
- IS assisting with MRI, CT and Plain Film. Additional WLIs and weekends planned.

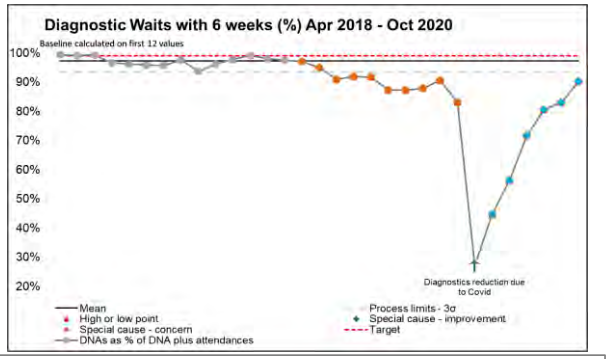
High level Board Performance Indicators & Benchmarking

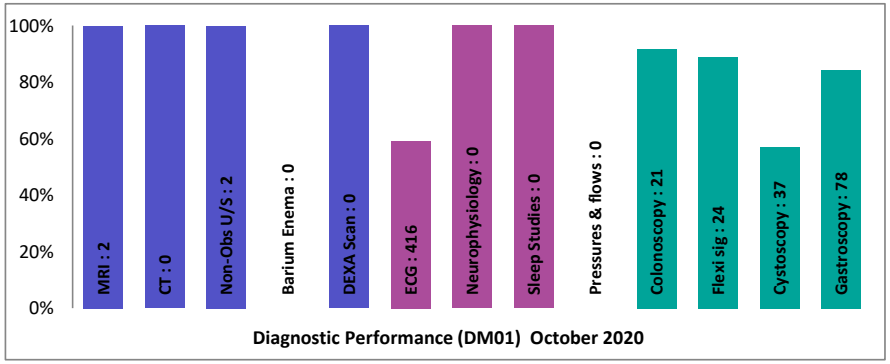
		Standard	Values	Merged Trust
Referral Rates				
GP Referral Rate year on year	*(values 19/20 v 20/21)*	-0.5%	73548 / 48264	-34.4%
Total Referrals Rate year on year +/-		-0.5%	129555 / 87788	-32.2%
Outpatient metrics				
Follow up backlog				13,722
Follow-Up Ratio		1.91		1.44
% DNA Rate	*(New & Flup Atts / Total DNAs)*	5%	28469 / 2144	7.0%
Patient cancellation rate	*(New & Flup Atts / Total Pat Canx)*		28469 / 3268	10.3%
reduction in face to face attendances				
% telemed/video attendances	*(Total Atts / Total Non F-F)*		28469 / 11948	42.0%
Diagnostic Performance (DM01)				
% of <6 week performance	*(Total / 6+ Weeks)*	1%	5930 / 580	9.8%

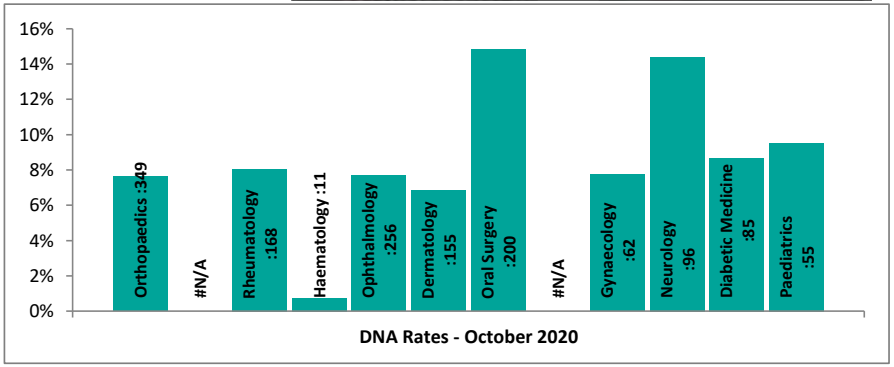
High Level Trust Performance











FINANCE

Commentary

On the 1 October a new national Financial Framework came into effect with the Trust being allocated a fixed funding envelope. This new framework no longer provides for a retrospective true-up to achieve financial balance. Instead the Trust has submitted a financial plan for the period to 31 March 2021 forecasting a £5.6 million deficit, inclusive of ongoing COVID-19 costs, Phase 3 recovery, and winter preparedness. During October the Trust is £26,000 behind plan reporting a £1.024 million deficit against a planned deficit of £998,000. CIP of £225,000 was achieved in month being £45,000 below target.

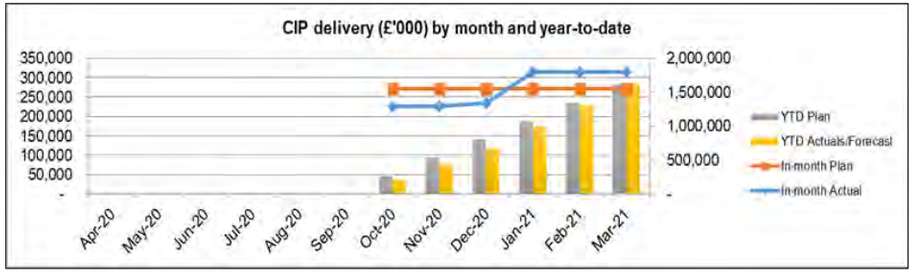
Year to date capital expenditure at the end of October amounted to £16.9 million against a plan of £27.8 million. This variance reflects the previously reported slippage and the Trust has now formalised a planned £6 million capital underspend as part of the overall Dorset ICS capital envelope.

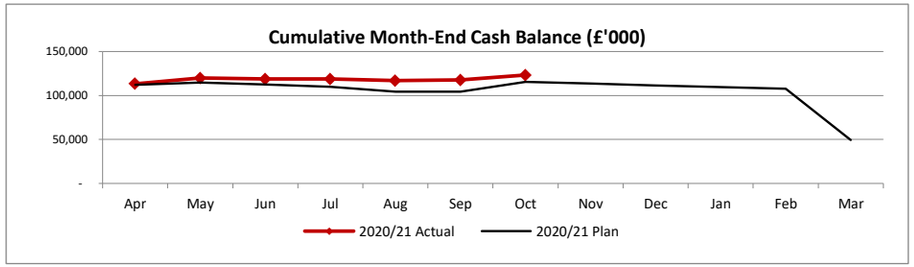
The Trust is currently holding a consolidated cash balance of £123.2 million, however this includes the November contractual payments of £51.8 million received in advance.

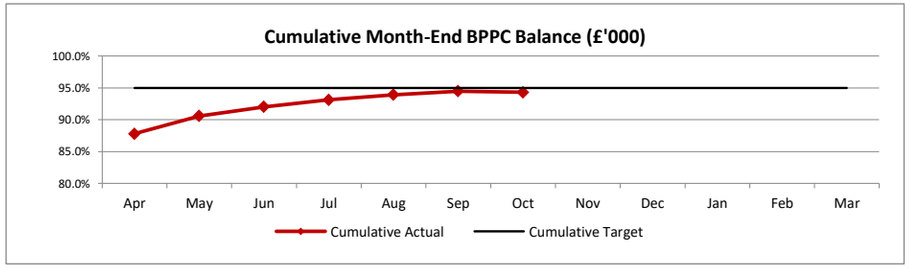
FINANCIAL INDICATORS	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000	Forecast Variance £'000
Surplus/ (Deficit)	(998)	(1,024)	(26)	0
Capital Programme	27,842	16,930	10,912	6,000
Closing Cash Balance	115,512	123,229	7,717	0
Public Sector Payment Policy	95%	94%	-1%	0

REVENUE	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000	Forecast Variance £'000
Surgical	(10,916)	(10,972)	(56)	0
Medical	(14,517)	(14,845)	(328)	0
Specialties	(12,895)	(12,304)	591	0
Operations	(1,912)	(1,851)	61	0
Corporate	(5,369)	(5,201)	168	0
Trust-wide	44,611	44,083	(528)	0
Surplus/ (Deficit)	(998)	(1,091)	(92)	0
Consolidated Entities	0	66	66	0
Surplus/ (Deficit) after consolidation	(998)	(1,024)	(26)	0
Other Adjustments	72	91	19	0
Control Total Surplus/ (Deficit)	(926)	(934)	(7)	0

CAPITAL	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000	Forecast Variance £'000
Estates	3,838	895	2,943	50
IT	4,965	4,833	132	1,460
Medical Equipment	5,074	2,390	2,684	(2,357)
Covid-19	1,400	1,400	0	0
Strategic Capital	12,565	7,412	5,153	6,847
Total	27,842	16,930	10,912	6,000







Performance at a Glance - Key Performance Indicator Matrix

			Aug-20	Sep-20	Oct-20	ytd	ytd var
Quality - SAFE							
Presure Ulcers (Cat 3 & 4)			12	6	10	88	55
Inpatient Falls (Moderate +)			5	2	3	25	10
Medication Incidents (Moderate +)			1	2	5	11	1
Patient Safety Incidents (NRLS only)			869	1282	761	5,489	4172
Hospital Acquired Infections		MRSA	0	0	0	0	0
		MSSA	1	2	3	20	3
		C Diff	7	7	1	38	3
		E. coli	3	12	4	37	19
Quality - RESPONSIVE							
Patient with 3+ Ward Moves (Non-Clinically Justified Only)			7	17	13	96	-24
Patient Moves Out of Hours (Non-Clinically Justified Only)			58	64	84	511	-156
ENA Risk Assessment		Falls	36%	30%	36%	61%	10%
**infection eNA assessment*		Infection*	40%	35%	41%	72%	N/A
went live at RBCH		MUST	37%	32%	40%	64%	10%
during April 20		Waterlow	33%	29%	34%	60%	8%
Quality - EFFECTIVE AND MORTALITY							
HSMR	Latest	(Jun 20 - RBH)				76.3	
	Latest	(Jun 20 - PHT)				86.0	
Patient Deaths		YTD	207	185	265	1385	**125**
Death Reviews		Number	53	27	6	241	**N/A**
Deaths within 36hrs of Admission			30	35	40	241	**8**
Deaths within readmission spell			15	13	15	98	**-57**
Quality - CARING							
Complaints Received			57	48	51	295	130
Complaint Response in month			57	48	51	291	145
Section 42's			0	2	1	8	9
Friends & Family Test			90%	-	-	91%	-
Quality - WELL LED							
Risks 12 and above on Register			36	38	39	39	-1
Red Flags Raised*			31	47	51	182	-171
*different criteria across RBCH & PHT							
Overall CHPPD			-	9.2	48.9	10.8	**2.8**
Patient Safety Alerts Outstanding			0	0	0	0	0

Elective & Theatres				
Referral To Treatment	**Aug-20**	**Sep-20**	**Oct-20**	**standard**
18 week performance %	**49.0%**	**56.2%**	**60.4%**	92%
Waiting list size	**41,172**	**43,123**	**44,320**	42,587
Waiting List size variance compared to Mar 19 %	**-3%**	**1.3%**	**4.1%**	0%
No. patients waiting 26+ weeks	**16,950**	**17,001**	**14,220**	
No. patients waiting 40+ weeks	**6,395**	**6,921**	**7,197**	
No. patients waiting 52+ weeks	**2,050**	**2,636**	**2,998**	0
Average Wait weeks	**20.8**	**20.6**	**19.5**	8.5
Theatre metrics				
Theatre utilisation - main	**67%**	**71%**	**71%**	98%
Theatre utilisation - DC	**70%**	**73%**	**59%**	91%
NOFs (Within 36hrs of being clinically fit - CCG)	**69%**	**10%**	**50%**	95%

Outpatients & Diagnostics				
Referral Rates	**Aug-20**	**Sep-20**	**Oct-20**	**standard**
GP Referral Rate year on year +/-	**-45.8%**	**-37.8%**	**-34.4%**	-0.5%
Total Referrals Rate year on year +/-	**-45.3%**	**-37.1%**	**-32.2%**	-0.5%
Outpatient metrics				
Follow up backlog	**13,652**	**13,941**	**13,722**	
Follow-Up Ratio	**1.46**	**1.44**	**1.44**	1.91
% DNA Rate	**5.7%**	**6.6%**	**7.0%**	5%
Patient cancellation rate	**9.2%**	**9.9%**	**10.3%**	
30% reduction in face to face attendances				
% telemedicine attendances	**52.9%**	**44.5%**	**42.0%**	25%

Diagnostic Performance (DM01)					
% of <6 week performance		19.5%	16.9%	9.8%	1%

CANCER

	Aug-20	Sep-20	Oct-20	Standard
62 day standard	76.6%	76.1%	-	85%
28 day faster diagnosis standard	80.3%	72.9%	-	75%

Emergency

Type 1 ED		Aug-20	Sep-20	Oct-20	Standard
Emergency Dept					
	Arrival time to initial assessment	5.7	5.7	5.1	15
	Clinician seen <60 mins	4065	4399	4664	
	PHT Mean time in ED	227	206	210	200
	RBCH Mean Time in ED	211	217	226	200
	Patients >12hrs from DTA to admission	0	0	0	0
	Patients >6hrs in dept	1833	1454	1540	
	ED attendance Growth (YTD)	-26.0%	-23.2%	-15.7%	
Ambulance Handover					
	Ambulance handover growth (YTD)			-6.7%	
	Ambulance handover 30-60mins breaches	313	228	249	
	Ambulance handover >60mins breaches	56	52	48	
Emergency Admissions					
	Emergency admissions growth (YTD)	-11.9%	-10.5%	-12.1%	

Patient Flow

		Aug-20	Sep-20	Oct-20	Standard
Bed Occupancy			85.9%	86.0%	85%
Stranded patients:					
	Length of stay 7 days		380	394	
	Length of stay 14 days		197	214	
	Length of stay 21 days		108	126	108
Non-elective admissions			6089	6279	
> 1 day non-elective admissions			3796	3932	
Same Day Emergency Care (SDEC)			2291	2346	
Conversion rate (admitted from ED)			34.40%	36.10%	30%

Workforce

		Aug-20	Sep-20	Oct-20	YTD	Variance
Turnover		10.40%	10.70%	10.40%	10.8%	-1.4%
Vacancy Rate		1.0%	0.7%	-	0.8%	-4.3%
Sickness Rate		4.2%	4.2%	-	4.2%	0.2%
Appraisals	Values Based	41.6%	53.5%	57.3%	36.8%	-15.9%
	Medical & Dental	52.0%	45.9%	37.5%	58.9%	-23.2%
Statutory and Mandatory Training		86.52%	86.96%	88.37%	87.0%	-1.8%

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University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PART 1 – COVER SHEET
Meeting Date: 25 November 2020

Agenda item: 8.3

Subject:	Mortality Report

Prepared by:	Alyson O'Donnell – Chief Medical Officer Divya Tiwari – Mortality Lead for UHD
Presented by:	Alyson O'Donnell

Purpose of paper:	This report advises the Board of Directors of the Mortality metrics within the Trust.
Background:	This is the first combined mortality report for the new organisation.
Key points for members:	The Board is asked to note the combined metrics which can now be reported by site All metrics are as or better than expected The divergence in Poole HSMR/SHMI persists but is no longer >3sd The Board is asked to note the methodology for the rapid, in depth, review of mortality associated with a Covid outbreak
Options and decisions required:	No decisions required
Recommendations:	For information
Next steps:	For information

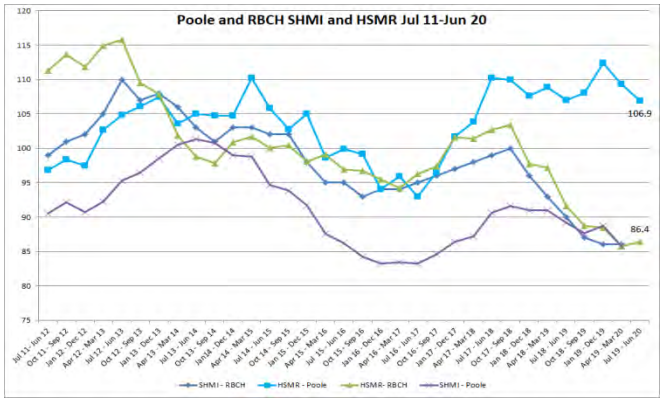
Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

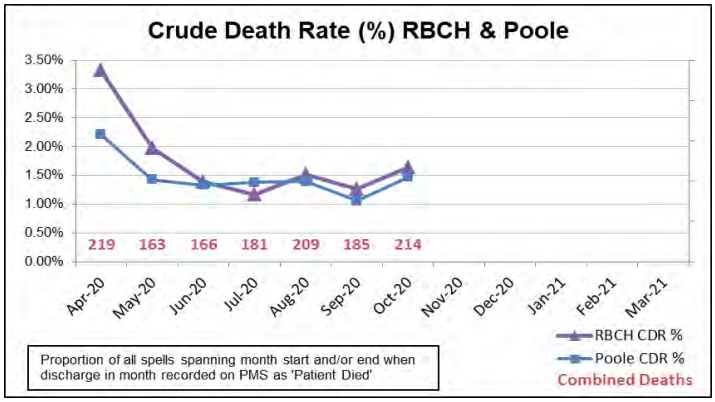
Committees/Meetings at which the paper has been submitted:	**Date**
Quality Committee	23/11/2020

University Hospitals Dorset
NHS Foundation Trust

Chief Medical Officer's Report to the Board

Mortality Update





HSMR/SHMI August 19 to July 20

Indicator	Site	Value	Range
HSMR	RBCH	85.9	Better than expected
	Poole	106.0	As expected
SMR	RBH	86.6	Better than expected
	Poole	104.9	As expected
SMHI	RBCH	85	Better than expected
	Poole	86	As expected

e-Mortality Reviews

Site	Jul-20	Aug-20	Sep-20	Oct-20
RBCH	33%	26%	11%	1%
Poole	40%	41%	34%	5%

Medical Examiner Screening

Site	Jul-20	Aug-20	Sep-20	Oct-20
RBCH	100%	100%	100%	100%
Poole	68%	95%	89%	96%

Deaths in Learning Disability

Site	Jul-20	Aug-20	Sep-20	Oct-20
RBCH	1	0	0	2
Poole	0	1	1	1

Deaths in Learning Disability

In last quarter UHDFT had 5 deaths in learning disability, all but one of these deaths have been reviewed internally three had a LeDeR review. The LeDeR review graded all deaths in the 'good care' category and there were no specific learning points identified at Trust level. One death was not referred via the Trust Safeguarding team and actions have been put in place to ensure we refer 100% of LeDeR mortality nationally.

Diagnostic and Procedural Alerts

The Dr Foster intelligence team presented its first combined report for the new organization to the November MSG meeting. This was also the first combined meeting attended by mortality speciality leads for both sites. The Mortality Policy and ToR for the UHDFT were tabled awaiting further comments and approval.

Dr Foster alert	Type of alert	site	Action plan	Completion date
Multiple myeloma	Diagnostic (Relative risk)	RBH	Case notes review	January 21
UTI	Diagnostic (Relative risk)	Poole	Case notes review	Second phase
Urethral catheterizati Of bladder	Procedural	Poole	Associated With UTI	Second phase
Other screening for Suspected condition	Data quality	Poole	Coding	December 20
Pneumonia	Relative risk	Poole	Case notes review	January 21

Covid 19 Mortality (Poole site)

The UHD Mortality Surveillance Group Chair called an extraordinary meeting to discuss the review of Covid 19 associated mortality following an outbreak at the Poole site. A thematic standardised mortality review will be undertaken by a single senior review in parallel with an independent review by a panel of mortality speciality leads outside the department and across the organisation. The findings will be concluded by the end of December. Duty of candour is being fulfilled for all cases and the MSG Chair will consider the dissemination of learning and any action plans accordingly.

MSG Presentations

Steve Trowbridge AKI lead for Bournemouth presented the annual review of AKI mortality and a new virtual referral and review system.

Dr Lucie Bishop presented a review of treatment escalation planning during the first wave of the 'Covid outbreak' and discussed actions for further improvements.

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25th November 2020

Agenda item:8.4

Subject:	Freedom to Speak Up Bi-annual report

Prepared by:	Helen Martin (Freedom to Speak Up Guardian, FTSUG)
Presented by:	Helen Martin (FTSUG)

Purpose of paper:	The purpose of this paper is to; • celebrate our progress in creating our speaking up culture within 2020/21, • understand why our staff are raising concerns and what we have learnt, • **APPROVE** annual board commitment to Sir Robert Francis principles and declaration of behaviours.
Background:	This paper is a bi-annual regulatory requirement to update the board on speaking up. The key points and statements will be discussed at the presentation including themes (including Covid related) and learning.
Key points for Board members:	The purpose of speaking up is to create a culture which keeps our patients safe and at the heart of everything we do. The paper requests the board to note: • New FTSU governance arrangements for UHD. • Key progress over 2020, including key papers such as Model Hospital, NHSI/E advisory board, HSJ and FTSU Index. • Case headlines including number of referrals, themes, Covid related themes, who and where concerns are raised. • **APPROVE** annual board commitment to Sir Robert Francis principles and declaration of behaviours.
Options and decisions required:	The paper requests the board to: **APPROVE** annual board commitment to Sir Robert Francis principles and declaration of behaviours.
Recommendations:	As above
Next steps:	Annual report May 2021

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	AF1: Deliver, safe, responsive, compassionate high quality care
BAF/Corporate Risk Register: (if applicable)	Not Applicable

CQC Reference:	ST13 Human Resources

Committees/Meetings at which the paper has been submitted:	Date

Freedom to Speak Up (FTSU)

Bi-Annual Report 2020/21

1.0 A Vision for Raising Concerns

Speaking up at University Hospital Dorset (UHD) is the cornerstone of our culture as a new trust. This is reflected in our new set of values following the cultural review undertaken by our cultural champions over the summer. Our people clearly described the need for a learning rather than blame culture, whereby we are able to make mistakes without feeling afraid to discuss them. Psychological safety and feeling confident to speak up were seen as contributing to safer, excellent quality care. As a result UHD are proud to have "I will be open and honest" as one of our values. Moreover, this work further reflects that on a national level. The NHS People Promise published "We each have a voice that counts" as a key promise, and from that at the National Guardian Office (NGO, 2019) "Anyone working in the NHS should be able to speak up about anything that gets in the way of delivering high quality patient care or that affects their working lives"

Our Freedom to Speak Up (FTSU) team provide a route to enable workers to do this when they feel unable to speak to their line manager or use other established processes. The FTSU team have developed a shared approach since 2019 and so has been able to embed this work in anticipation of our merger. This report will show that our people are speaking up across all sites of University Hospital Dorset, endorsing the significant steps that we have so far taken to creating a healthy speaking up culture, in order to protect patients and improve the experience of our NHS workers.

The purpose of this paper is to;

- celebrate our progress in creating our speaking up culture within 2020/21,
- understand why our staff are raising concerns and what we have learnt,
- APPROVE annual board commitment to Sir Robert Francis principles and declaration of behaviours.

2.0 Speaking up at UHD

The FTSU Model at UHD has developed since 2019 when a shared approach was approved in front of merger. Existing experiences alongside guidance and recommendations from the NGO, National Health Service Improvement (NHSI) and national experience have all helped shape this model. It also benchmarked with the recommendations set out in 2019 by the NGO, meeting the elements recognised as essential for staff so that they can speak up.

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The model has a full time Freedom to Speak Up Guardian (FTSUG) working across all sites supported by FTSU Ambassadors (FTSUA) at each site.

2.1 Vision

To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

2.2 The Freedom to Speak Up (FTSU) Team

The FTSU team is now well established across all sites of UHD. The Freedom to Speak up Guardian (FTSUG), Helen Martin, was appointed in April 2017 and leads the team. Our team of Freedom to Speak Up Ambassadors (FTSUA) were set up to help ensure that workers who need to speak up can do so easily by tackling a number of challenges posed by factors such as geographic spread and workforce size, whilst giving workers choice about the individual they would want to approach. The development of this team has not only been instrumental in developing our diversity but has also helped improve our access and resilience if the FTSUG was not available. Their role is to promote, listen, support and provide an impartial view to staff when speaking up.

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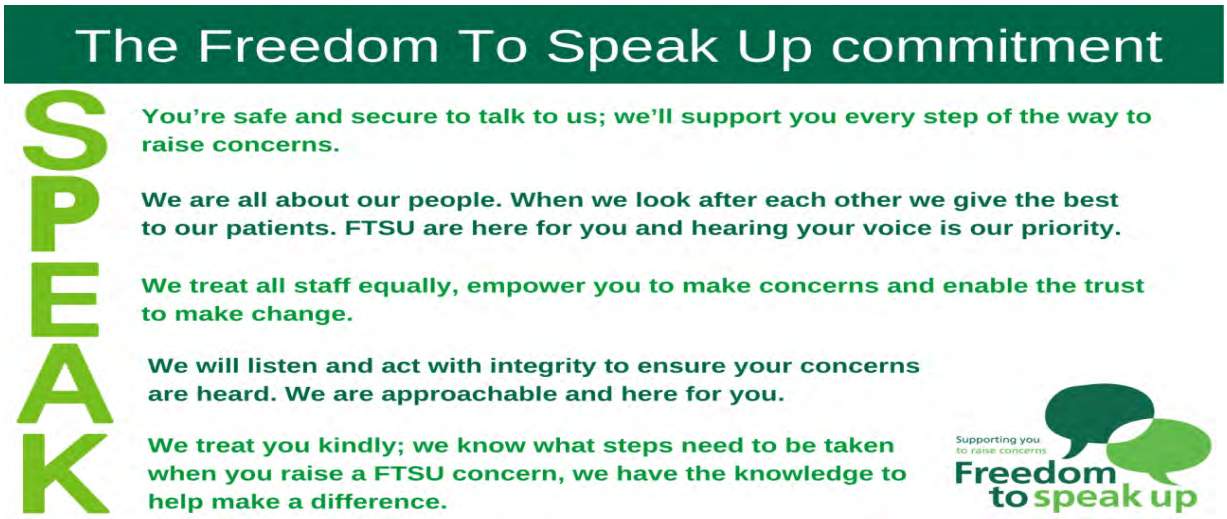
The FTSU Team (from left to right):

Dr Carly Slinger	Chief Resident/ ST4 Older People's Medicine
Joy Johnson	Biochemist and BAME network lead
Tara Vachell	Registered Nurse Degree Apprentice
Hazel Rodriguez	Pensions Lead
Sally Papworth	Preadmission Assessment Sister
Jillian Ireland	Professional Midwifery Advocate (absent from photo)
Declan McConville	Chaplain
Catherine Bishop	Education &Training Course Co-ordinator and Apprenticeship Co-ordinator
Helen Martin	FTSUG
Dr David Morgan	Associate medical director for safety and consultant physician in general and respiratory medicine (absent from photo)
Dr Anjanee Shah,	Chief Resident/ Dermatology CESR Trainee (absent from photo)

In celebration of our merged Trust, the FTSU team refreshed our branding, logos and messages to reflect our one team. Our branding is strong and sends a clear message to our people of who we are, what we do, why speaking up is important and the difference it makes. We are particularly proud to have created our FTSU commitment to our people which we launched during our speaking up month this year in October alongside a short video from us.



Supporting you to raise concerns
Freedom to speak up

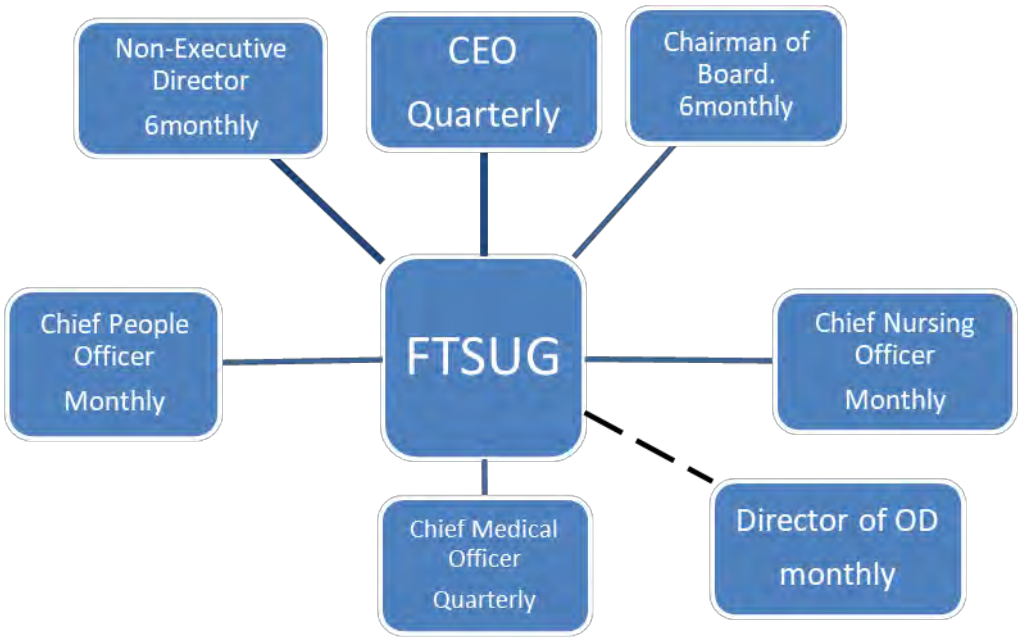
3.0 Key Progress during 2020/21

3.1 Re-launch of Freedom to Speak Up: Raising concerns (whistleblowing) policy

The Board approved our UHD Freedom to Speak Up policy as part of its day 1 critical policies. The policy not only refreshes the University Hospitals Dorset status and the governance structure (refer to section 3.2) but it now includes our Clinical Commissioning Group, Dorset as another point contact for staff if they needed to approach an external body. This reflects the recent work our Dorset FTSU Network, chaired by Helen Martin has started (refer to section 3.8). This network is looking to approach speaking up in a more local and integrated system way, and this step is one example of how we have done this.

3.2 UHD speaking up Governance

UHD is proud to confirm that its governance for speaking up is now supported by our Non-Executive Director, Christine Hallett. This role will be alongside our executive lead which remains our CEO, Debbie Fleming. Both roles are key sources of advice and support for their FTSUG and will meet regularly. There is also open direct access in between these times. The NHSE/I set out clear guidance for these roles, amongst other roles in the board, and the FTSUG plans to outline these at their meetings. The FTSUG has also extended this guidance to include other senior leadership positions in the new Trust so that we can encourage a collective leadership approach to speaking up.



The FTSU will be governed within the Workforce Strategy Committee and will meet quarterly, reporting a bi-annual report prior to the Board and then by exception at other meetings.

The FTSUG will continue to present a paper to the Board bi-annually and in person in line with best practice as outlined by the NGO.

2020- 2022	
Workforce Strategy Committee	**Board of Directors**
	May 2020
	November 2020
December 2020	
February 2021	
April 2021 (annual report)	May 2021 (annual report)
August 2021	September 2021
December 2021	
February 2022	
April 2022	May 2022

3.3 FTSU Commitment of the Board

Alongside our new governance arrangements, the FTSUG requests that the new board publically commit to the Sir Robert Francis principles of speaking up on an annual basis alongside a declaration of their behaviours. This commitment is a visual statement, supporting the vision of speaking up and by committing to developing a culture of safety. The declaration of behaviours sets out how we will role model this and sets the tone of the culture for the new trust.

ACTION: Approve Board Commitment and declaration of behaviours (Appendix A).

3.4 Speaking up Month and the Power of our Networks

Speak Up Month is the highlight of our calendar and is a chance to raise awareness of Freedom to Speak Up and the work which is going on to make speaking up business as usual. This October, we celebrated the third Speak Up Month which happened to coincide with the launch of UHD. Throughout October we contributed to sharing our Alphabet of Speak Up – from Anonymity to Zero Tolerance. 26 days to explore the issues, the people, the values, the challenges – everything which goes into what Freedom to Speak Up means in health. UHD had some national coverage under "Y, You said, we did" when we shared our work with one of our international doctors. This work was presented at the last board report but can be accessed also by opening the following link: https://youtu.be/X41TYS0JNcU.

Alongside this work we connected with our networks (LGBTQ+, BAME, European and disability) and walked jointly our clinical and non-clinical areas with our award winning decorative roaming trolley (NGO, 2017 runners up in the National Communications Category). We visited all 3 sites of UHD (50 areas), spoke to over 700 staff and delivered newly designed and logo pens, literature and testimonial information. We had both internal and external coverage and have seen up to 23 referrals since which is up 65% (average) from September. We also worked with our library colleagues and hosted an innovative fishbowl event where we interactively discussed what speaking up is and had some staff who were able to describe their own experience of speaking up. The diagram below shows some pictures of this work.

Diagram 1: Pictures to illustrate our Speaking up month

3.5 NHS staff survey: Freedom to Speak up Index

The FTSU Index, first published in 2019, is a key metric for organisations to monitor their speaking up culture. The average index has risen nationally from 75.5% in 2015 to 78.7% in 2019. When compared to other sectors, a score of 70% is perceived as a healthy culture. It is also recognised that organisations with higher FTSU scores are associated with higher performing organisations as rated by Care Quality Commission (NGO, 2020).

The purpose of the index is to promote the sharing of good practice and learning, by encouraging trusts to work to improve their speaking up arrangements and culture. The national report in 2019 published case study from RBCH of good practice and since then continue to be contacted to share our learning.

Table 1: FTSU Index

FTSU report Publication	PHT	RBCH	National Average
2019	79%	84% *	78.1%
2020	80.3% (↑1.3%)	84.1% (↑0.1%)	78.7%

*highest FTSU index score for Acute Trusts

The FTSU index is calculated from four questions in the NHS Staff Survey and relate to whether staff feel knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident. The table shows that both sites have improved in their index score and both remain above the national average.

3.6 Advisory Group to NHSE/I National FTSU team

UHD were approached by NHSE/I to join a national FTSU Advisory Group and provide non-binding strategic advice and contribute to the development of national FTSU Guidance/Policy. The role of the group is to provide advice on issues raised by NHSE/I, encourage and support the exploration of new ideas and challenge NHSE/I to help us improve our support offer. We are delighted that our CEO has agreed to be a member of this group. This role will allow us review our current model and practices and shape national policy. It is another example of how our leaders support speaking up and want to shape its future.

3.7 Care Quality Commission (CQC)

CQC inspections recognise the strong link between the quality of management and leadership and the quality of its services. Listening and responding to people who speak up, and tackling the barriers to speaking up, is a natural ingredient of good leadership, which itself has always been a significant element of the CQC-rating process. Consequently the CQC assess a trust's speaking up culture under the key line of enquiry (KLOE) 3 as part of the well-led question. Further to this there is more emphasis as part of a newer inspection process to set up more regular engagement meetings. The FTSUG has met with our CQC engagement team in August, building good links and assurance.

3.8 FTSU Networks

The NGO recognises the need to develop and engage within formal regional networks. The FTSUG is an active member of the southwest region. This forum is excellent for support and sharing good practice. The FTSUG is a frequent speaker at regional meetings and is also facilitating work to external bodies on behalf of the NGO.

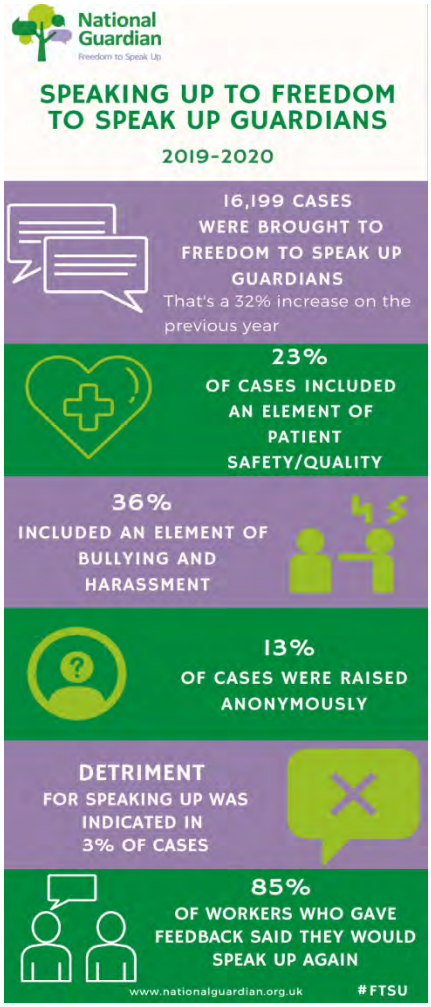
The FTSUG has also set up and chairs a local Dorset FTSU Network since September 2018. The vision of this group was agreed to share best practice, look to act as a mentor for difficult cases. The membership has since expanded and now has representation across CCG, private healthcare, ambulance service, acute trusts and our regional lead for NGO. The focus of these meetings has consequently changed to supporting speaking up across our multi-agency systems in Dorset. Examples of integrated system working have included representing speaking up across Dorset quality surveillance groups where learning has been shared with our primary colleagues or linking our staff in our speaking up policy to our CCG colleagues for advice if an external body is being considered.

3.9 National Guardian Office (NGO)

The FTSUG continues to be an active contributor to the work from the NGO. Part of this work is to submit and support requirements from the NGO. These include quarterly submissions, census information and other surveys.

3.9.1 NGO data

Quarterly information about speaking up cases are submitted to the NGO, outlining the themes and reporting the feedback received from those cases closed. Data from UHD will occur from quarter 3 2020/21 and changes to the system are now in place.



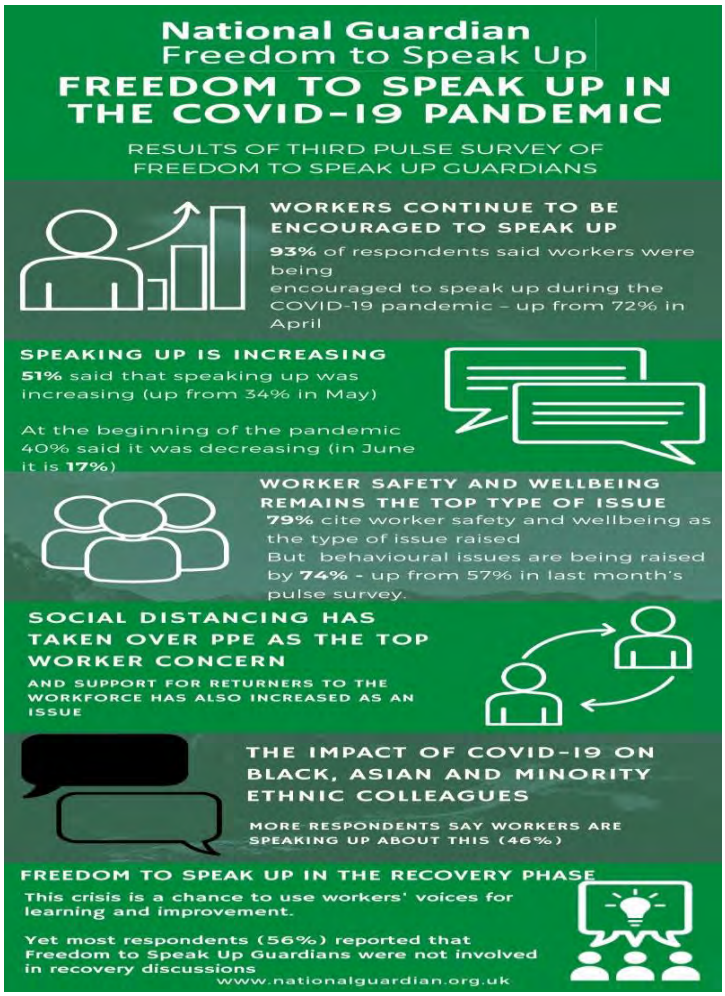
The NGO published its latest data (2019/20) report in October, revealing that last year Freedom to Speak Up Guardians received 16,199 speaking up cases. The number of cases year represent a 32 per cent increase on the previous year (12,244 cases) and more than double the number of cases handled two years ago (7,087) when data commenced.

Dr Henrietta Hughes noted within the report *"Why do some workers speak up anonymously? Why are workers fearing or actually suffering detriment? What are we doing to address bullying and harassment? These are questions that leaders need to ask so workers are not fearful about speaking up. This will bring about real improvements and help to make speaking up business as usual."*

3.9.2 NGO publication: Pulse Surveys during COVID-19 pandemic

The COVID-19 pandemic is an unprecedented challenge to the health and care sector, putting enormous pressure on workers. FTSUG continue to support workers in the midst of this crisis to ensure that their voices are listened to and responded to. To understand how Freedom to Speak Up is being supported, the NGO undertook 3 pulse surveys of the guardian network between April to June.

The surveys showed that speaking up continued during the pandemic. Worker safety and wellbeing were the most frequently raised type of issues raised. Social distancing, PPE and support to staff returning to work were often cited and an increasing acknowledgement of the impact COVID had on our BAME colleagues.



The impact of COVID at both our Poole and Bournemouth sites mirrored the national picture. The FTSUG fed back initial COVID findings at the last board meeting in May. Key observations are included in the table overleaf. Further observations and detailed analysis can be found in section 4.2.

Table 2: Initial observations of concerns over COVID pandemic (13th March- 13th May 20)

	PHT	RBCH
Attitudes	4	8
Other	1	1
Performance	1	
Policies/process	3	5
Quality and Safety	3	7
Staffing levels		1
Total	**12**	**22**
Referrals same period 2019	5	9

No of cases raised were substantially increased from same period 2019 at both sites. A number of quality issues raised at Poole (25%) and RBCH (32%) site.

	PHT	RBCH
Dr	1	2
Nurse	5	11
HCA		
Midwives		
AHPs	1	3
AHP pharmacy		
Admin/Clerical	1	4
Ancillary		
Corporate service	3	1
Other		1
Anon	1	
TOTAL	12	22

Our nursing workforce raised the most concerns at both sites. 1 anonymous concern at Poole.

Care Groups/Divisions	PHT	RBCH
CCG A		4
CCG B		6
CCG C		4
Corporate		8
Womens Children and Oncology	5	
Surgical	1	
Medical	1	
Clinical and Operational Care	1	
Corporate	4	

Cases spread across all care groups at RBCH but focused more at womens, child and oncology and corporate functions at PHT.

3.9.3 Freedom to Speak Up training programme

'Speak Up, Listen Up, Follow Up', is a new e-learning package, launched end of October and is aimed at anyone who works in healthcare. Divided into three modules, it explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best. This training follows the National guidelines on Freedom to Speak Up training in the health sector in England published by the National Guardian's Office in 2019 and presented within the September 2019 board report. These guidelines will be reviewed later in 2021.

The National Guardian's Office, in association with Health Education England, has launched the first module aimed at all workers as part of its annual Speak Up Month campaign. The first module 'Speak Up' is Core Training for all workers including volunteers, students and those in training, regardless of their contract terms. Its aim is to help everyone working in health to understand what speaking up is, how to speak up and what to expect when they do. Access is via Health Education England's e-Learning for Healthcare https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/. The FTSUG will work with the education and training department further to see how this can be embedded within our current training programme. The remaining module for managers and senior leaders will follow later in the year.

3.10`Freedom to Speak up Strategy (2019-2021)

A strategy for speaking up was approved by the board in May 2020 and set out our vision, ambition and aims based on a diagnosis of issues the trust is currently facing in relation to speaking up. The strategy has been aligned to each organisation's objectives and a detailed work plan is in place to measure its delivery. The FTSUG continues to adhere to this strategy and will use this to shape the development of 2021/2022 objectives, set later this year.

3.11 Healthcare Service Journal: Freedom to Speak Up Organisation of the Year

Speaking up at Royal Bournemouth and Christchurch Hospitals: An International Medical Graduate (IMG) experience has been successfully shortlisted for the HSJ Freedom to Speak up Organisation of the Year. This award refers to the work we have been undertaking with our IMGs following feedback raised to the FTSU team. Quotes such as "I feel like an outcast and isolated" or "I clearly frustrate others and soon become excluded" were common. IMGs are a vital part of the workforce, often bridging rota gaps. Through the feedback from the FTSU team and a survey carried out by our education team in 2018, highlighted that we are not preparing IMGs adequately for their jobs or supporting them once in post, particularly around speaking up about bullying behaviours. A programme called International Doctor Support Initiative (IDSI) was subsequently set up, promoting a network for peer support mentoring, to facilitate speaking up as well as offering leadership and teaching opportunities. All of this work has promoted a culture of speaking up which has in turn has mitigated culture shock and social isolation. This work alongside the support of the FTSU team, have been able to restore the IMGs confidence of their medical ability and career choices as well as support their health and wellbeing and reduce loneliness and isolation.

The judging process is planned to take place at the end of January and the Awards will be taking place virtually on Wednesday 17th March.

3.12 The Model Hospital

The Model Hospital is an NHS digital information service designed to help the NHS improve productivity, quality and efficiency. It enables health systems and trusts to compare their productivity and quality, and identify opportunities to improve by diving deeper into your data and compare with peers to understand what good looks like and identify areas for improvement.

The NGO have been working with NHSE/I and published a newly developed 'Culture and Engagement' module. This new area of the Model Hospital has been populated with a range of speaking up indicators, including data from Freedom to Speak Up (FTSU) Guardians in

NHS trusts on the speaking up cases raised with them. It also gives a holistic picture of what the culture looks like and begin to examine the impact Freedom to Speak Up is having within organisations. Key data is represented below. The FTSUG is attending NGO training on this data and will report any further trends in annual report.

Table 3: Key data from the Model Hospital

	PHT	RBCH	National Medium
FTSU index (2019)	80.3%	84.1%	78.3%
% change in FTSU index over 3 calendar years	0.3%	3.8%	2.2%
Total cases reported to FTSUG per 1000WTE (Q4, 2019)	3.86	4.95	2.91
Bullying and Harassment cases per 1000WTE (Q4, 2019)	1.21	1.03	0.89
Pt safety and quality reported per 1000WTE (Q4, 2019)	1.69	0	0.49
Cases of detriment per 1000WTE (Q4, 2019)	0	0	0
FTSU cases reported anonymously per 1000WTE (Q4, 2019)	0.24	0	0.09
Staff friends and family % recommended: care	84.1%	86.7%	80.7%
Last time saw error you reported it (2019, 16c)	97%	95%	95%
When errors reported, my organisation takes action to ensure it does not happen again (2019, 17c)	68%	81%	71%
We are given feedback about changes made in response to reported errors (2019, 17d)	56%	69%	62%
Secure about raising concerns about unsafe practices (2019, 18b)	73%	77%	72%
I am confident that my organisation would address my concern (2019, 18c)	58%	77%	60%
Staff sickness (March 2020)	3.85%	5.78%	5.40%
Staff turnover (July 2020)	1.4%	1.2%	1.06%
Proportion temporary staffing (Feb 2020)	5.72%	2.06%	3.99%
CQC rating safe	Requires improve	Good	

This data in table 3, illustrates a strong culture of speaking up at both sites when looking at the national medium. In terms of FTSU index, RBCH was awarded the best acute trust in 2019 and has had a significantly stronger improvement over the last 3 years. PHT has seen a slightly slower pace to improvement but remains above the national medium.

Both sites raised more concerns to the FTSUG than the national medium illustrating that our staff are aware of this route to escalate concerns. In terms of cases raised to the FTSUG, PHT heard more safety and quality cases and bullying and harassment as compared to RBCH. PHT also received more anonymous cases as compared to the national medium which needs further exploration.

The Model Hospital also looked at the questions within the staff survey. Questions relating to addressing concerns (18c), giving feedback (17d), taking action (17c) and feeling secure (18b) were all lower from staff at PHT than RBCH and in the first 3 questions (18c, 17d and 17c) were lower than the national medium. Staff from PHT were however more likely to report errors (16c).

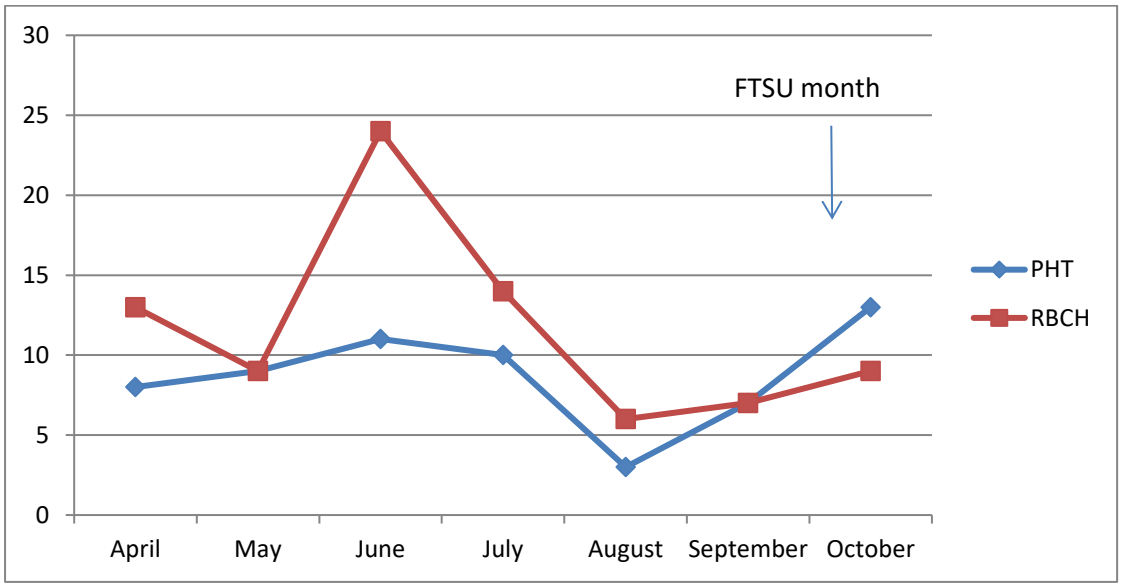
In terms of other data, Poole report a lower staff sickness but carry a higher staff turnover and proportion of temporary staffing. CQC rated Poole with a safety rating of requiring improvement.

4.0 Case Referrals – the headlines

A range of data is collected by the FTSUG. This report will look at this data including the key themes of concerns raised, where concerns have been raised and by whom. Referrals come from a number of routes including team presentations, trust communications, website, signposting from other departments such as OH and HR, word of mouth, LERNs and recommendation.

The graph overleaf shows the number of referrals over 2020. You will note the peak of referrals at RBH were received during June, following the first wave of the pandemic. In contrast whilst referrals did increase at Poole at this time the peak of referrals has followed the work the FTSU team have done over speaking up month October. Thirteen referrals were received during October at Poole and nine at RBH.

Graph 1: Monthly number of referrals raised to FTSU team



4.1 Key Themes of concerns

Table 4 (overleaf) illustrates the number of cases heard through the FTSU team. It is this data that forms part of what is submitted quarterly to the National Guardian Office (NGO).

Table 4 shows that the leading reason why staff approach the FTSU team is to do with process and policy. Fifty per cent of issues raised included management processes such as appraisals, return to work support, rotas, feedback from interviews, supporting staff through merger, support during formal processes, sickness management and coding. A number of these issues clearly will have needed expert HR advice and further signposting with the FTSU team supporting them during this time (refer to section 4.3).

Another common theme raised with the FTSU has an element of behaviours and attitudes. The NGO recognises bullying and harassment as a key theme and similar themes are seen across the network. This area continues to be looked at reviewing the mechanisms to support staff to tackle poor behaviours and attitudes. Additional literature, support and more trained mediators have been key areas of work. Its aim is to help provide the tools for staff to role model behaviours which underpin our values, to provide feedback when this does not happen and then feel empowered to tackle poor behaviours if they were to arise.

Ten per cent of referrals were related to quality and safety issues. These issues were seen in quarter 1 and 2 and over the first COVID wave. All these issues were escalated (refer to section 4.3) and are described further below.

	Poole				RBH				XCH				UHD TOTAL
Themes	Qtr 1 **(April –**	Qtr 2 **(July – Sept)**	Qtr 3 **(End Oct)**	**TOTAL**	Qtr 1 **(April –**	Qtr 2 **(July –**	Qtr 3 **(End Oct)**	**TOTAL**	Qtr 1 **(April –**	Qtr 2 **(July – Sept)**	Qtr 3 **(End Oct**	**TOTAL**	
Attitudes & Beh	10	8	7	**25**	16	9	2	**27**		2		**2**	**54**
Other	1			**1**									**1**
Performance Capab	1			**1**									**1**
Policies/process	15	9	6	**30**	22	11	6	**39**		2		**2**	**71**
Quality & Safety	3	1		**4**	7	3		**10**					**14**
Staffing Levels					1		1	**2**					**2**
TOTAL	**30**	**18**	**13**	**61**	**46**	**23**	**9**	**78**		**4**		**4**	**143**
COVID related				**15 (25%)**				**34 (44%)**		**0**		**0**	**49 (34%)**
2019	3	22	26		17	24	13		2		1		

Table 4 : Themes raised through the FTSUG office

Supporting you to raise concerns
Freedom to speak up

4.2 Covid related themes

Thirty-four per cent of total referrals across all sites were related to COVID issues. Table 4 and 5 illustrates that RBH site raised the most Covid related concerns with 44% of referrals. Of these referrals nearly a third were related to staff re-deployed to other areas. These issues included staff feeling that they were working beyond their scope of confidence, perceived lack of support from both their new team and home team and changes to their usual working conditions such as hours of working and PPE.

Twenty-five per cent of referrals made at Poole were related to Covid issues with guidance for staff being the main theme. These issues included rotas, role clarity, ESR coding, risk assessment. Notably staff were coming to the FTSU team concerned more about issues relating to health and wellbeing of themselves or teams and looking for guidance of where to get support or further enhanced help.

Table 5: Covid related themes raised to FTSU team

	PHT	RBH
Guidance policy for patients	1	3
Guidance policy for staff	9	9
Protection and testing	3	6
Work environment	1	4
Decision/Comms		2
Operational	1	
Staff re-deployment		10
TOTAL	15 (25%)	34 (44%)

Alongside these messages the FTSUG also shared some lived experiences from staff who came to the FTSU team. The quotes are presented in the diagram overleaf (diagram 2).

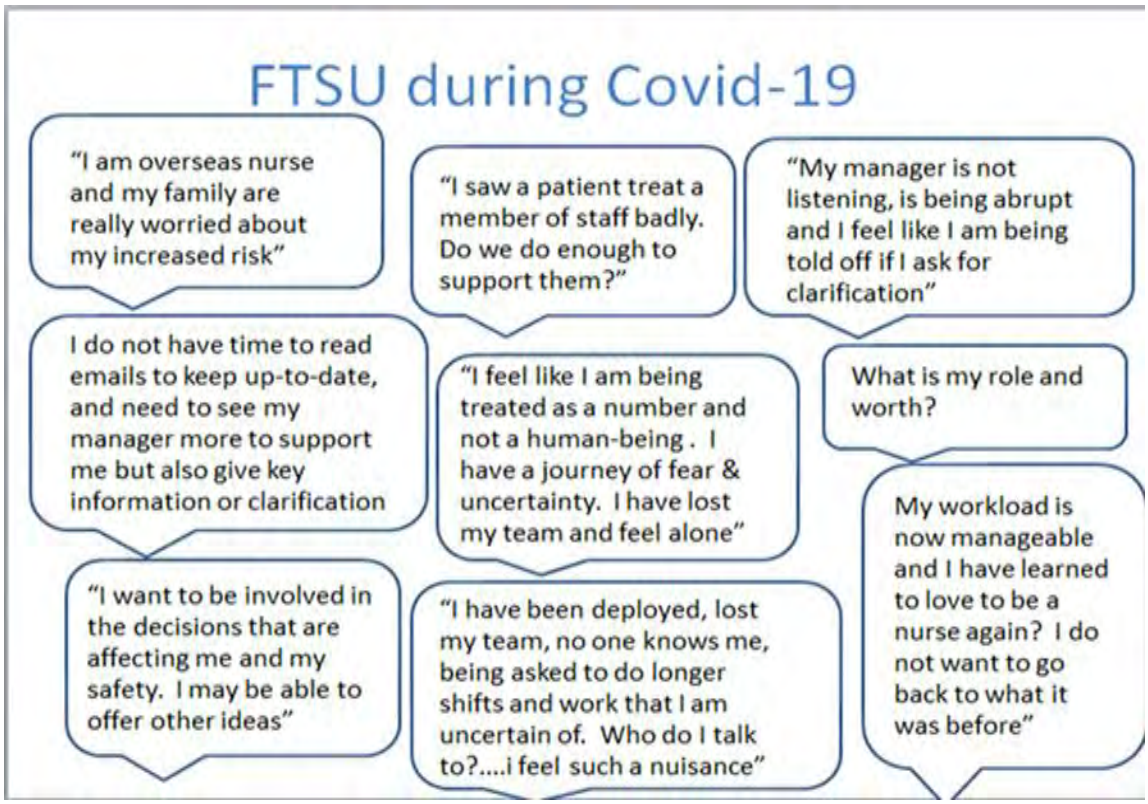


Diagram 2: Lived experiences from our staff over Covid times.

The Trust has focused on the learning from these themes and the diagram below illustrates what the Covid related themes were and what we did with this information to improve the experience and safety of our staff and patients.

Guidance policy for patients •Guidance for patients with additional more complex needs •Guidance on visiting restrictions •Guidance for patients if refuse to wear masks/adhere to guidance	Refreshed Infection control guidance. Increased comms
Guidance policy for staff •Risk assessments - not being completed/ammendments not made. •ESR coding and sickness management advice. •Guidance when team member sent home with COVID symptoms •Rota changes that feel unfair •Worried about x team and do not know how to support them	HR FAQ, Refreshed guidance on ESR coding, refreshed health and wellbeing offer and intranet, staff briefings, training for debriefing
Protection and testing Advice on where masks and scrubs to be worn Masks - access and guidance	Infection control guidance. Line management visibility and listening events. Feedback
Work Environment •Decision for those who can work at home & those who have to come in •Access for space to work/risk assessments •Shielding staff and other duties	HR FAQ, Management guidance on homeworking, HR shielding advice
Decision/comms staff with knowledge and skills of some decisions not being able to influence the direction of travel. Dificult decsions were not always made in person and receiving this via email has been poor Decisions were often found out via rumours rather than my line manager. It felt they were hiding.	HR FAQ, leader visibility, staff briefing, debriefing training
Operational Not clear of future service Concern about volume of patients whilst restrictions	New operational structure in place
Staff re-deployment •being asked to complete duties beyond scope of practice •Shift hours and PPE breaks •Who to escalate issues/ unclear if new or home team? •Unknown when return to substantive role •Exhausted and burnt out. 12 hr shifts awful	Staff debriefing and listening, rotations and voluntary placements. Team training. Matron feedback

Service concerns

Supporting you to raise concerns
Freedom to speak up

4.3 Outcome of referrals

Table 6 illustrates what became of referrals once they were made to the FTSU team. Of those referrals, the majority of cases were escalated to the line manager to investigate and action. In 30-37% of cases (Poole/RBH respectively), cases were signposted to experts in the field of the concern such as HR, OH or other including infection control, risk and governance or our security experts. Upto 16% of cases were escalated to director or executive level from RBH and 8% at Poole site. These issues would be deemed as needing senior leadership/direction or immediate action.

Table 6: Outcome of referrals received by FTSU team

		Poole	RBH	XCH
Line manager		28	30	4
FTSU advice		9	6	
Escalate to CNO/DOO		5	13	
Signpost	HR	7	17	
	OH	4	2	
	Network	3	3	
	Other	5	7	
TOTAL (end Oct)		61	78	4

4.4 Who are raising concerns?

Table 7 shows that our shows nurses accounted for the biggest portion (40%) of speaking up cases raised with Freedom to Speak Up team, followed by our administrative staff (26%) and Allied Health Professionals (AHPs; 13%). Two staff felt necessary to remain anonymous, both cases at Poole and needs further investigation as to why this is the case. This figure remains lower than the national figure of 13% (refer to section 3.9.1).

Special attention needs to paid to engage with our medical workforce which is down 3.5% from last year. We are proud that our FTSU team now has 3 doctors within it to work on improving this and already have plans to present with BMA, attend and present to grand round, core induction and working with Medical Director, Guardian of working times and lead Medical Educator. Another challenge for 2020 will be our catering and cleaning/maintenance experts. Plans are ready in place with booked presentations and future walkabouts.

Table 7: Staff who are raising concerns to the FTSU team

	Poole	RBH	XCH	TOTAL UHD
	April – end Oct			
Dr	1	3		**4**
Nurse	22	33	2	**57**
HCA	5	2	1	**8**
Midwives	6			**6**
AHPs	7	12		**19**
AHP pharmacy		2		**2**
Admin/Clerical	16	20	1	**37**
Cleaning/catering/ maintenance/ancillary	2	3		**5**
Board Members		1		**1**
Corporate service		2		**2**
Other				
Anon	2			**2**
Total	**61**	**78**	**4**	**143**

Another area of the workforce that needs focus is that within minority groups of the organisation. The Francis Freedom to Speak Up reviews highlighted that minority staff, including black and minority ethnic (BAME) workers, feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in these reviews, also showed that minority staff groups are more likely to suffer detriment for having spoken up. The National Guardian Office (NGO) case reviews at Southport and Ormskirk Hospital NHS Trust highlighted the importance for every Trust and FTUSG to ensure that work reaches this group of staff and that their voice is also being heard.

Eleven per cent of staff who raised a concern at Poole and fifteen per cent at Royal Bournemouth were from a BAME background. All staff were signposted to our BAME networks who were also able to support and advise. The FTSUG is an integral member of the Equality, Diversity and Inclusion Committee and will continue to work together to improve and support our BAME employee experience.

4.5 Where are concerns being raised?

Significant effort has been made to ensure that the FTSU team visit and meet all members of staff across each site and the ambassador model allow for this. Tables 8 and 9 outline the concerns raised within the old and newer organisational structures. The FTSUG monitors this closely so to ensure that all areas are aware of the FTSU service and how to use it.

Table 8: The number of concerns raised in Clinical Care Groups (2020; Q1,2)

Qtr 1 and 2	PHT	RBCH	XCH
Medical	8		
Clinical and Operational	3		
Surgical	7		
Oncology, Children and women's	19		
Corporate	10		
Anon	1		
Total	**48**		
CCGA		20	
CCGB		15	2
CCGC		10	1
Corporate/operations		24	1
Total		**69**	**4**

Table 9: The number of concerns raised in UHD (2020; Q3)

Care Group	Directorate	PHT	RBH	XCH	Total
Surgical	Surgery	1			1
	Critical care		2		2
	Head and Neck	1			1
	MSK				
Medical	Urgent and Emergency	1			1
	Acute Medicine				
	Older persons and Neuro	2			2
	Medicine 1				
	Medicine 2				
Specialties	Cancer Care	1			1
	Child Health				
	Women's Health				
	Clinical Support	2	7		9
	Pathology	1			1
Operations	Facilities				
	Clinical Site				
	Emergency Planning				
	Operational Performance				
Corporate		3			3
Anon		1			1
TOTAL		13	9		22

5.0 Summary

University Hospitals Dorset commences its new organisation in a strong position in supporting its people to speak up. Our new values explicitly state the importance of having open and honest conversations and supports the work of our FTSU team. Both sites come to UHD with good performance data as illustrated within the Model hospital and FTSU Index. Challenges remain and barriers need to reduced. Working collectively on the issues our people raise with be key and addressing poor behaviours and quality issues remains our most important piece of work for the future. It is in our gift to lead and support this work, as outlined in our strategy and thereby achieve our vision whereby we have a world class culture of safety. As a board it will be vital to be exceptional role models, challenging our own behaviours, gaining feedback from those who we work with and giving feedback when we see those who do not meet the Trust values.

APPENDIX A

UHD Board of Directors' Statement of Commitment to the principles of the Freedom to Speak up

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication Freedom to Speak Up. The Board of Directors is committed to fostering a culture of safety and learning in which all staff feel safe to raise a concern across the Trust.

Speaking up is essential in any sector where safety is an issue. Speaking up should be something that everyone does and is encouraged to do. There needs to be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up will persist.

The Board supports the key principles of speaking up and is committed to leading the actions required to implement them. The Board will receive support from the Freedom to Speak up Guardian (FTSUG) who is sponsored by the Chief Executive.

The key principles the Board is committed to include:

	Principle	Action
1	Culture of safety	Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.
2	Culture of raising concerns	Raising concerns should be part of the normal routine business of any well led NHS organisation.
3	Culture free from bullying	Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
4	Culture of visible leadership	All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.
5	Culture of valuing staff	Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.

6	Culture of reflective practice	There should be opportunities for all staff to engage in regular reflection of concerns in their work.
7	Raising and reporting concerns	All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.
8	Investigations	When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
9	Mediation and dispute resolution	Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.
10	Training	Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
11	Support	All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality.
12	Support to find alternative employment in the NHS	Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.
13	Transparency	All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
14	Accountability	Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns.
15	External Review	There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report
16	Coordinated Regulatory Action	There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns
17	Recognition of organisations	CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
18	Students and Trainees	All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
19	Primary Care	All principles in this report should apply with necessary adaptations in primary care.
20	Legal protection	Should be enhanced to those who make protected disclosures.

Speaking up ANNUAL DECLARATION

This declaration is to be signed annually alongside our statement of commitment to the Sir Robert Francis recommendations

Declaration

Please tick the statements below to confirm that you remain.

- ☐ I recognise that I have a responsibility for creating a safe culture and an environment which workers are able to highlight problems and make suggestions for improvement.
- ☐ I understand the importance of workers feeling able to speak up and the trusts vision to achieve this
- ☐ I recognise the impact of my own behaviour on the trust's culture. I will therefore reflect on my own behaviour regularly so that it does not inhibit someone speaking up*.
- ☐ I have insight into how my power could silence truth
- ☐ I will welcome approaches from workers and thank them for speaking up. I will ensure that I will provide feedback
- ☐ I will speak up, listen and constructively challenge one another during board meetings
- ☐ I will seek feedback from peers and workers and reflect on how effectively they demonstrate the trust's values and behaviours
- ☐ I will accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.
- ☐ I will be open and transparent and see speaking up as an opportunity to learn.

*It is good practice to test your behaviour with direct and incidental feedback from staff surveys, pulse surveys, social media comments, reverse mentoring, 360 feedback and appraisals.

Signed: _____ Date: _____

Name in block letters: _____

Supporting you to raise concerns
Freedom to speak up

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 November 2020

Agenda item: 9.1

Subject:	Strategy & Transformation Update (Including Estates)

Prepared by:	Stephen Killen
Presented by:	Richard Renaut, Chief Strategy and Transformation Officer

Purpose of paper:	To provide an update to the Board of Directors on key aspects of communication relating to the construction changes across Bournemouth and Poole Hospital sites.
Background:	Our three sites of Bournemouth, Poole and Christchurch will see significant change over the next 5 years. These changes will impact our staff and patients who visit the site. This update lays out the key changes on our Bournemouth and Poole sites in the coming 12 months, and sets out a communications plan for how we will engage all our stakeholders.
Key points for Board members:	The board are asked to note the impact on key areas. The board are asked to note that a timetable of communications by month will be developed and shared with Execs and the board from the 1st December. 3 x attachments (Comms paper and 3 x appendix included): • Main communications paper for noting • Presentation summarising the cross site changes; • Poole Brochure highlighting the main strategic changes on the Poole site • Poole neighbour leaflet showing some of the immediate changes and providing our neighbours with key contacts
Options and decisions required:	N/A
Recommendations:	To support the Trust wide engagement of staff and patients regarding the changes to our Hospitals.
Next steps:	• Finalise the engagement timetable by the 1st December • Communicate with Stakeholders in line with the Communications plan.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	To transform and improve our service in line with the Dorset ICS and the long-term plan.

BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
Reconfiguration Oversight Group	Nov 2020
Trust Management Group	Nov 2020

UHD construction – managing change 2020 to 2024

November 2020

Focus on RBH site

January 2021

Start of Pathology Hub ground works on Wessex Fields

Impact

Minimal impact on the Trust

Noise to the staff in the Stour Building

Ongoing Timeline

- Jan 2021 Ground works start for pathology on Wessex Fields site

Location of Pathology Build

February 2021

Car Park A is permanently Shut

Car Park H (Consultants) shuts

Creation of the constructor's compound phase 1

Begin creation of the new circular road around the site

Impact

Loss of car park spaces

Action

Additional spaces agreed at Littledown Centre for staff use

Ongoing Timeline

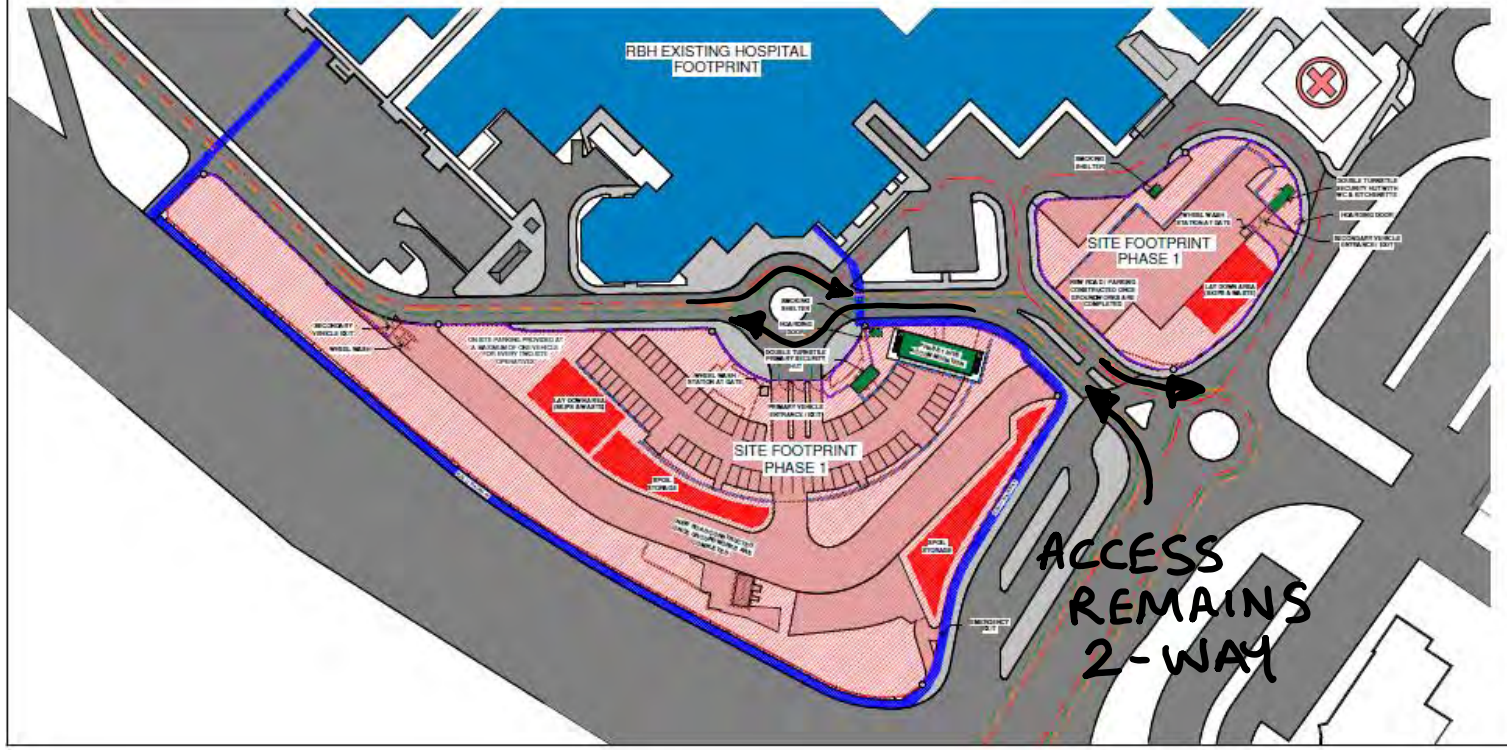
- Jan 2021 Ground works start for pathology on Wessex Fields site
- Feb 2021 Car Parks A and H shuts

Car parks A & H

IHP Site Compound – Phase 1

PARKING LOT A 3D VISUAL

PARKING LOT B 3D VISUAL



SITE LOGISTICS LEGEND

IHP

Developing One NHS in Dorset

POOLE AND BOURNEMOUTH HOSPITAL

SITE LOGISTICS PLAN PHASE 1

February 2021

- Orthopaedic Entrance taken out of service to create new retail pharmacy
- Plus internal works for the creation of the new general office and Lily Suite
- Main entrance remains open at this stage

Impact

- Loss of spaces in car park B

Action

- Spaces agreed for use at the Village
- Spaces agreed for use at the Littledown

Ongoing Timeline

- Jan 2021 Ground works start for pathology on Wessex Fields site
- Feb 2021 Car Parks A and H shuts
- Feb 2021 Orthopaedic entrance shuts

Location of Pathology, Car Park A, H and Orthopaedic OPD

February 2021

- Building work starts at Eye Unit & Jigsaw to create New West Entrance including "grab & go" café – access will be maintained throughout.
- Main entrance will be open during this time

Impact

- Road access will be limited due to narrowing for construction

Ongoing Timeline

- Jan 2021
  Ground works start for pathology on Wessex Fields site
- Feb 2021 Car Park A and H Car Park shuts
- Feb 2021 Orthopaedic entrance shuts
- Feb 2021 West Entrance work commences

Location of Pathology, Car Park A, H, Orthopaedic OPD, and West Entrance

PROPOSED FRONT ELEVATION

Ongoing Timeline

- Jan 2021 Ground works start for pathology on Wessex Fields site
- Feb 2021 Car Parks A and H shuts
- Feb 2021 Orthopaedic entrance shuts
- Feb 2021 West Entrance work commences

Feb 2021 – July 2021 Construction

- July 2021 Orthopaedic Entrance reopens with new retail pharmacy
- New Lily suite opens

Ongoing Timeline

- Jan 2021 Ground works start for pathology on Wessex Fields site
- Feb 2021 Car Parks A and H shut
- Feb 2021 Orthopaedic entrance shuts
- Feb 2021 West Entrance work commences

Feb 2021 – July 2021 Construction

- July 2021 Orthopaedic Entrance reopens with new retail pharmacy
- July 2021 New West Entrance completed

Ongoing Timeline

- Jan 2021 Ground works start for pathology on Wessex Fields site
- Feb 2021 Car Parks A and H shut
- Feb 2021 Orthopaedic entrance shuts
- Feb 2021 West Entrance work commences

Feb 2021 – July 2021 Construction

- July 2021 Orthopaedic Entrance reopens with new retail pharmacy
- July 2021 New West Entrance opens
- July 2021 Main entrance closes

Ongoing Timeline

- Jan 2021 Ground works start for pathology on Wessex Fields site
- Feb 2021 Car Parks A and H shut
- Feb 2021 Orthopaedic entrance shuts
- Feb 2021 West Entrance work commences

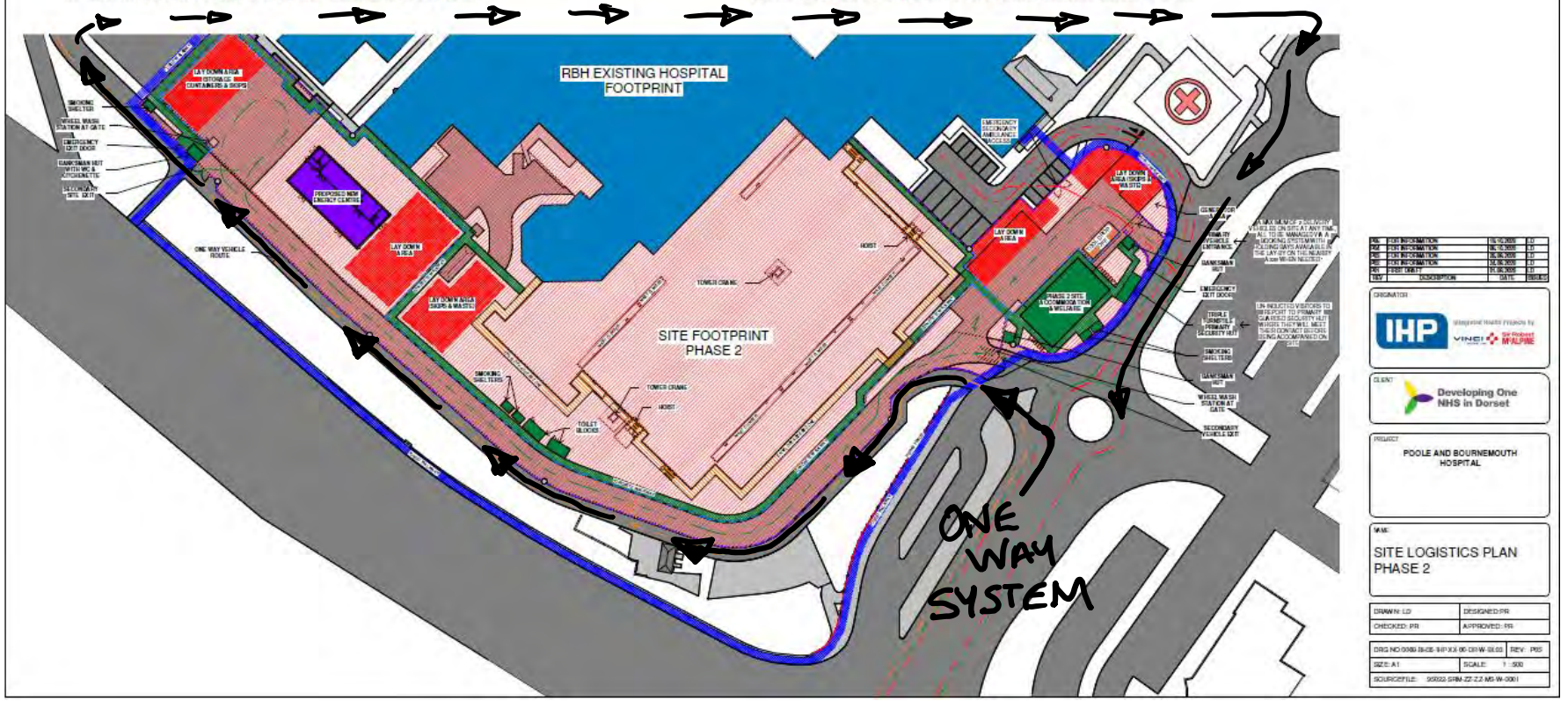
Feb 2021 – July 2021 Construction

- July 2021 Orthopaedic Entrance reopens with new retail pharmacy
- July 2021 New West Entrance opens
- July 2021 Main entrance closes
- September 2021 New road completed

IHP Site Compound – Phase 2

SECONDARY VEHICLE EXIT & STORAGE CONTAINER 3D VISUAL

PRIMARY VEHICLE ENTRANCE & SITE ACCOMMODATION 3D VISUAL



Ongoing Timeline

- Jan 2021 Ground works start for pathology on Wessex Fields site
- Feb 2021 Car Parks A and H shut
- Feb 2021 Orthopaedic entrance shuts
- Feb 2021 West Entrance work commences

Feb 2021 – July 2021 Construction

- July 2021 Orthopaedic Entrance reopens with new retail pharmacy
- July 2021 New West Entrance opens
- July 2021 Main entrance closes
- September 2021 New road completed
- September 2021 phase 2 of compound commences
- One Way System start clockwise around the site

Ongoing Timeline

- Jan 2021 Ground works start for pathology on Wessex Fields site
- Feb 2021 Car Parks A and H shut
- Feb 2021 Orthopaedic entrance shuts
- Feb 2021 West Entrance work commences

Feb 2021 – July 2021 Construction

- July 2021 Orthopaedic Entrance reopens with new retail pharmacy
- July 2021 New West Entrance opens
- July 2021 Main entrance closes
- September 2021 New road completed
- September 2021 phase 2 of compound commences
- One Way System start clockwise around the site (3 years)

October 2021 MCEC build commences

Autumn 2024:
Maternity, Childrens, Emergency and Critical Care Completed!

Other changes on RBH site 2021-26

- Possible modular building for clinical uses
- Installation / upgrades to Interventional Radiology, CTs,
- Possible refurb to offices of Stour building
- Refurbishments of multiple areas to create wards (e.g. once current Pathology moves to its' new building)

More detailed briefings and timelines to follow in separate updates.

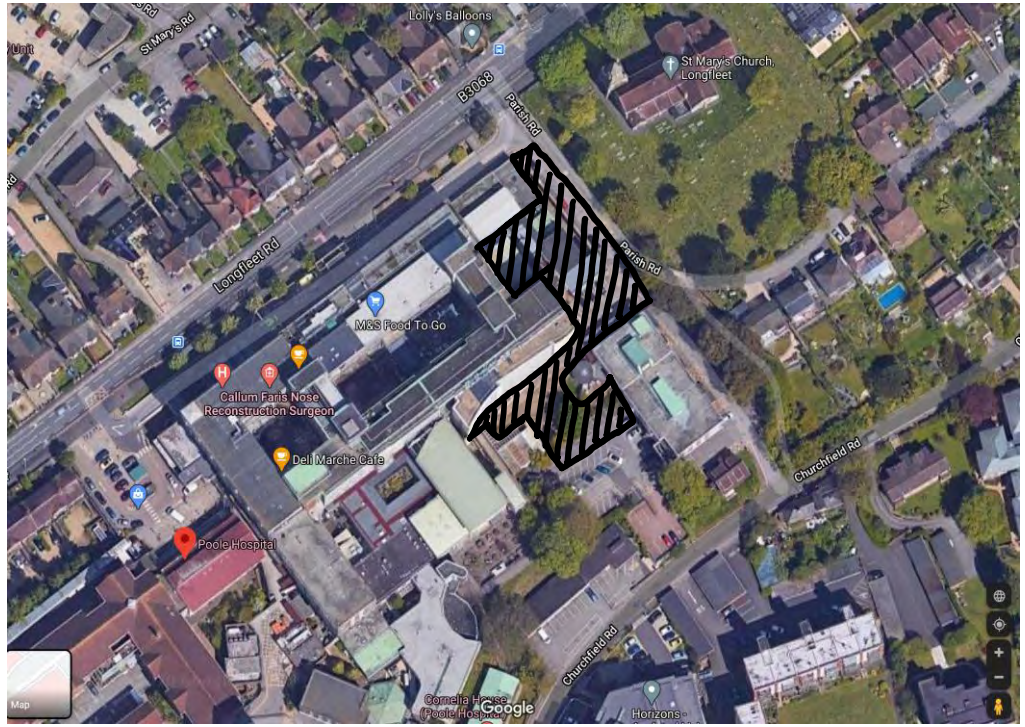
Preparations for the disruptions

- Staff engagement (including partners) - encourage flexible working where possible
- Public engagement (including elected members, neighbours)
- Volunteers engagement
- Signage improved and updated regularly
- Appointment letters and leaflets - encourage the continued use of virtual appointments
- IHP Interface with the staff and public, and sub-contractors
- Trial golf buggies and mobility support for disabled access
- Additional off-site parking for staff: Littledown Centre (& some at Village)
- Continued home working where appropriate
- Additional off site office accommodation options
- Encourage use of sustainable transport (bus, bike etc) to reduce parking/traffic
- Key points of contact / feedback including "real time" responses
- "Considerate contractor" check lists, including when very noisy works happening

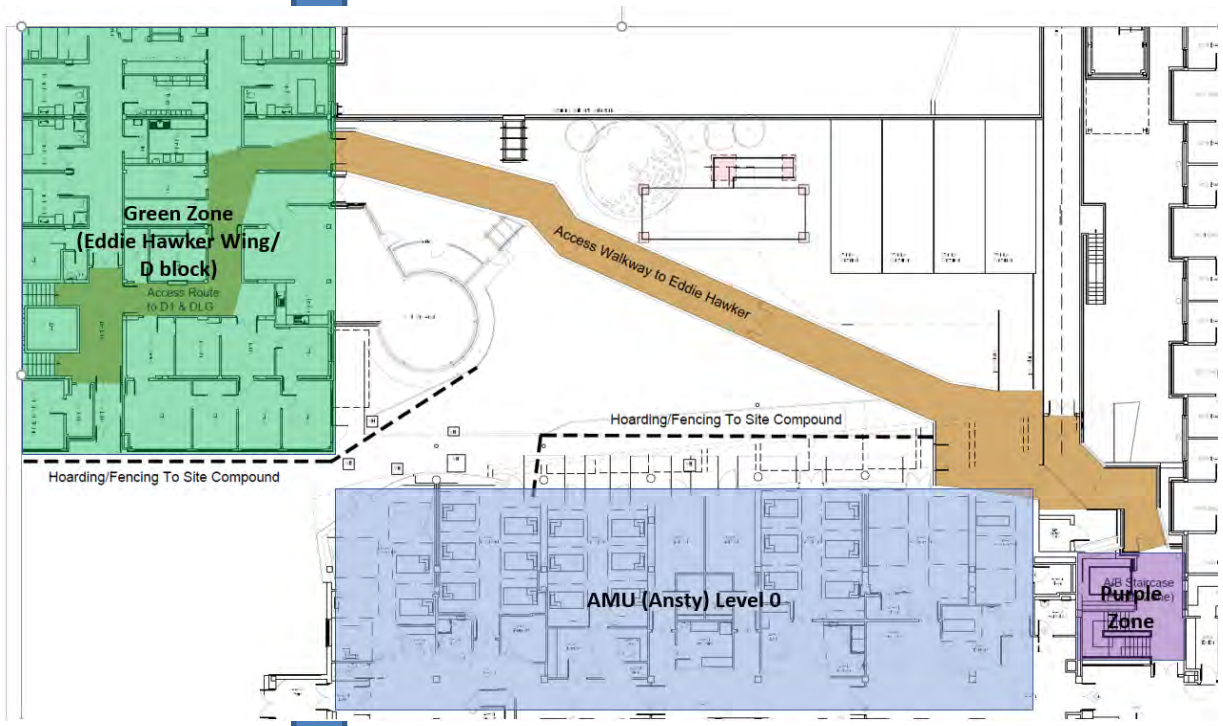
Ancient Proverb

You have to crack eggs to make an omelette!

Poole Comms Timetable



- Oct 2020 New Eddie Hawker Access completes
- Nov 2020 Eddie Hawker Access open to staff and patients
- Nov 2020 Parking outside Eddie Hawker ceases



RBH Comms Timetable

Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21

PH Comms Timetable

Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21	Aug 21

University Hospitals Dorset
NHS Foundation Trust

UHD construction: managing change (2020-2024)

Outline Communications Plan – Focus on RBH site (Jan-Sept 2021)

November 2020

v3.1

1. Introduction

As a result of all the building works to create the major emergency hospital at RBH, there will be considerable change and disruption. The Atrium will be closed for the creation of the new main entrance and concourse. The start of these enabling works is in late January 2021, beginning with the road around the site. The atrium will close in the Autumn 2021.

The West entrance – Eye Unit / Jigsaw - will be improved as this will be the main entry point for most staff and visitors. Work on this will start in January and complete by July 2021.

Another early change is that after consideration of several options, the charity team, PALS and volunteers will need to move into the trust management area, on the first floor East Wing for 3 years, before they move to their permanent home, back in the main entrance and concourse.

Looking further ahead, from late 2024 the whole trust management area will be refurbished and turned into a clinical area. At this point there will need to be another set of office changes as part of a wider review of the whole UHD estate

This project this is part of an overall £250m reorganisation of NHS services across Dorset and will see RBH become the main centre for emergency services and Poole Hospital the main centre for planned treatment.

2. Aims of the communications plan

This plan is to ensure the change programme, at RBH and its aims and objectives are clearly communicated to all patients and staff as well as key external stakeholders

Author: Richard Moremon, head of communications (transformation)

It will also ensure that audiences receive updates on the progress of developments, as well as information on interim arrangements during the enabling period. This plan runs in parallel with one that focuses on the site changes at Poole Hospital.

3. Key messages

Overall

- The site changes at both RBH and PH are extensive, but necessary for our future.
- There is a complex programme of works to keep both sites fully operational throughout
- The timetable is very tight, and we have to stick with it to open on time (and budget)

Changes associated with RBH atrium:

- Main entrance and atrium will be a central focal point for RBH site
- The atrium will have an increased range of services and teams within it
- There will be a new central reception desk plus the retention of the new reception at the newly formed West Entrance
- New improved offices for PALS including more individual rooms for private conversations
- New offices for the charity team to promote their work and fundraising
- New porters lodge in a central location within the organisation; this will be built early in the project and will be available by July 2021
- Increased range of retail and beverage outlets
- New centrally located spiritual centre for multi-faith prayer and quiet contemplation
- New first floor changing / shower facilities for staff
- Interim plans will be in place during the period

4. Audiences

All internal audiences should be aware of the programme of work. In addition, these key audiences/groups should be aware of specific information relevant to their area:

- RBH staff
- Patients / Patient reps
- Volunteers
- Board
- Governors
- Media
- Commercial partners

5. Communications channels

The full suite of existing communications channels will be used to promote the work taking place. Key channels include:

Channel	Content	Owner	When
Internal Communications			
Intranet	Regular front page updates, providing links to resources, information about the project eg.FAQ etc	RM > info supplied by programme manager	See indicative timetable
Screensaver	High level information regarding changes	RM > info supplied by programme manager	See indicative timetable
Staff bulletin	Regular articles explaining the work and rounding up progress/plans during enabling period etc.	RM > info supplied by programme manager	See indicative timetable
Posters	Poster 1 : Awareness building – 'coming soon' Poster 2 : supporting plans during decant period For display on main corridors, lift areas etc.	RM > info supplied by programme manager	See indicative timetable
The Brief	Item on the monthly briefing to senior clinical and non-clinical managers	RM > info supplied by programme manager	See indicative timetable
Stakeholder publications	Positive story via internal publications eg. new quarterly members' magazine	RM > info supplied by programme manager	See indicative timetable
External Communications			
Media	• Public announcement once work commences (see draft) • Proactive social media posts	RM > info supplied by programme manager	See indicative timetable
Monitoring	Scanning and circulation of cuttings/digital coverage. Comms to flag up concerns and draft responses as required.	Comms team	TBC

6. Responsibilities

The communications lead will coordinate communications activity, supported by the programme lead. Individual project leads will be expected to share good news with the communications lead for onward dissemination.

7. Indicative Timetable

Month	Milestone	Comms theme	
January 2021	Start of Pathology Hub ground works on Wessex Fields • Car Park A and H (Consultants') Car Park shuts • Creation of the new circular road around the site • Creation of the constructor's compound	• Creation of the new circular road around the site • Creation of the constructor's compound	• Start of project media release (see appendix) • Staff weekly bulletin • January 2021 The Brief • Screensaver/intranet portal • Debbie Fleming video message
February 2021	• Orthopaedic Entrance taken out of service to create new retail pharmacy • Building work starts at the eye unit and Jigsaw entrance to create New West Entrance	• Main entrance remains open at this stage • Loss of spaces in car park B -spaces agreed for use at the Village • West Entrance work commences	• Staff weekly bulletin • February 2021 The Brief • Screensaver/intranet portal • Debbie Fleming video message
July – September 2021	• Orthopaedic entrance reopens • New West Entrance opens • Main entrance closes • New road completed	• Maintain updated timeline • 'You said, we did' reflecting any 'in project' changes during the enabling work	• Ongoing staff comms and public engagement

	• Phase 2 of compound commences and consultant's car park closes		
October 2021	• MCEC build commences	• Major comms campaign to mark the build phase of this project	• Local/national media

8. Framework for communications

- Staff engagement (including partners) - encourage flexible working where possible
- Public engagement (including elected members, neighbours)
- Volunteers engagement
- Signage improved and updated regularly
- Appointment letters and leaflets - encourage the continued use of virtual appointments
- IHP Interface with the staff and public, and sub-contractors
- Trial golf buggies and mobility support for disabled access
- Additional off-site parking for staff: Littledown Centre (& some at Village)
- Continued home working where appropriate
- Additional off site office accommodation options
- Encourage use of sustainable transport (bus, bike etc) to reduce parking/traffic
- Key points of contact / feedback including "real time" responses
- "Considerate contractor" check lists, including when very noisy works happening

9. Integration with Poole Hospital site communications plan

Oct 2020: New Eddie Hawker Access completes. Internal comms with new access arrangements

Nov 2020: Eddie Hawker Access open to staff and patients, parking outside Eddie Hawker ceases

- Launch of Poole Hospital site brochure
- Distribution of local Poole site newsletter for neighbours, with covering letter from chief executive

10. Measurement

The effectiveness of this communications plan will be measured in a number of ways:

- Number of articles appearing in trust publications
- Awareness among staff of the changes (via an on-line survey?)
- Number of visits to the intranet section

The effectiveness of this plan will be reviewed and amended as required.

Appendix: Draft announcement for launch of the enabling works (internal comms only)

Enabling work starts ahead of the building phase for major emergency hospital

Work to create the new major emergency hospital at Royal Bournemouth Hospital is about to begin. In the preparation phase there will be considerable change and disruption. During this phase the Atrium will be closed for the creation of the new main entrance and concourse. The start of these works is enabling works in late January 2021, beginning with the road around the site.

After consideration of several options, the charity team, PALS and volunteers will move into the management area for the 3 years, before they move to their permanent home, back in the main entrance and concourse once the overall project is completed.

Looking further ahead, from late 2024 the whole management area will start to be refurbished and turned into a clinical area. At this point there will need to be another set of office changes as part of a wider review of the whole UHD estate

This project this is part of an overall £250m reorganisation of NHS services across Dorset and will see RBH become the main centre for emergency services and Poole Hospital the main centre for planned treatment.

Richard Renaut, chief strategy and transformation officer, said: “Whilst we understand the disruption these changes will cause, the start of this work is great news as it marks the start of our plans to develop RBH as the major emergency hospital.

“We recognise that this change will affect a number of departments, which is why we’ve made it a priority to give each of them an alternative home in the hospital. During this period disturbances will be kept to a minimum and we thank staff for their support during this period.”

University Hospitals Dorset
NHS Foundation Trust

UHD construction: managing change (2020-2024)

Outline Communications Plan – Focus on RBH site (Jan-Sept 2021)

November 2020

v3.1

1. Introduction

As a result of all the building works to create the major emergency hospital at RBH, there will be considerable change and disruption. The Atrium will be closed for the creation of the new main entrance and concourse. The start of these enabling works is in late January 2021, beginning with the road around the site. The atrium will close in the Autumn 2021.

The West entrance – Eye Unit / Jigsaw - will be improved as this will be the main entry point for most staff and visitors. Work on this will start in January and complete by July 2021.

Another early change is that after consideration of several options, the charity team, PALS and volunteers will need to move into the trust management area, on the first floor East Wing for 3 years, before they move to their permanent home, back in the main entrance and concourse.

Looking further ahead, from late 2024 the whole trust management area will be refurbished and turned into a clinical area. At this point there will need to be another set of office changes as part of a wider review of the whole UHD estate

This project this is part of an overall £250m reorganisation of NHS services across Dorset and will see RBH become the main centre for emergency services and Poole Hospital the main centre for planned treatment.

2. Aims of the communications plan

This plan is to ensure the change programme, at RBH and its aims and objectives are clearly communicated to all patients and staff as well as key external stakeholders

Author: Richard Moremon, head of communications (transformation)

It will also ensure that audiences receive updates on the progress of developments, as well as information on interim arrangements during the enabling period. This plan runs in parallel with one that focuses on the site changes at Poole Hospital.

3. Key messages

Overall

- The site changes at both RBH and PH are extensive, but necessary for our future.
- There is a complex programme of works to keep both sites fully operational throughout
- The timetable is very tight, and we have to stick with it to open on time (and budget)

Changes associated with RBH atrium:

- Main entrance and atrium will be a central focal point for RBH site
- The atrium will have an increased range of services and teams within it
- There will be a new central reception desk plus the retention of the new reception at the newly formed West Entrance
- New improved offices for PALS including more individual rooms for private conversations
- New offices for the charity team to promote their work and fundraising
- New porters lodge in a central location within the organisation; this will be built early in the project and will be available by July 2021
- Increased range of retail and beverage outlets
- New centrally located spiritual centre for multi-faith prayer and quiet contemplation
- New first floor changing / shower facilities for staff
- Interim plans will be in place during the period

4. Audiences

All internal audiences should be aware of the programme of work. In addition, these key audiences/groups should be aware of specific information relevant to their area:

- RBH staff
- Patients / Patient reps
- Volunteers
- Board
- Governors
- Media
- Commercial partners

5. Communications channels

The full suite of existing communications channels will be used to promote the work taking place. Key channels include:

Channel	Content	Owner	When
Internal Communications			
Intranet	Regular front page updates, providing links to resources, information about the project eg.FAQ etc	RM > info supplied by programme manager	See indicative timetable
Screensaver	High level information regarding changes	RM > info supplied by programme manager	See indicative timetable
Staff bulletin	Regular articles explaining the work and rounding up progress/plans during enabling period etc.	RM > info supplied by programme manager	See indicative timetable
Posters	Poster 1 : Awareness building – 'coming soon' Poster 2 : supporting plans during decant period For display on main corridors, lift areas etc.	RM > info supplied by programme manager	See indicative timetable
The Brief	Item on the monthly briefing to senior clinical and non-clinical managers	RM > info supplied by programme manager	See indicative timetable
Stakeholder publications	Positive story via internal publications eg. new quarterly members' magazine	RM > info supplied by programme manager	See indicative timetable
External Communications			
Media	• Public announcement once work commences (see draft) • Proactive social media posts	RM > info supplied by programme manager	See indicative timetable
Monitoring	Scanning and circulation of cuttings/digital coverage. Comms to flag up concerns and draft responses as required.	Comms team	TBC

6. Responsibilities

The communications lead will coordinate communications activity, supported by the programme lead. Individual project leads will be expected to share good news with the communications lead for onward dissemination.

7. Indicative Timetable

Month	Milestone	Comms theme	
January 2021	Start of Pathology Hub ground works on Wessex Fields • Car Park A and H (Consultants') Car Park shuts • Creation of the new circular road around the site • Creation of the constructor's compound	• Creation of the new circular road around the site • Creation of the constructor's compound	• Start of project media release (see appendix) • Staff weekly bulletin • January 2021 The Brief • Screensaver/intranet portal • Debbie Fleming video message
February 2021	• Orthopaedic Entrance taken out of service to create new retail pharmacy • Building work starts at the eye unit and Jigsaw entrance to create New West Entrance	• Main entrance remains open at this stage • Loss of spaces in car park B -spaces agreed for use at the Village • West Entrance work commences	• Staff weekly bulletin • February 2021 The Brief • Screensaver/intranet portal • Debbie Fleming video message
July – September 2021	• Orthopaedic entrance reopens • New West Entrance opens • Main entrance closes • New road completed	• Maintain updated timeline • 'You said, we did' reflecting any 'in project' changes during the enabling work	• Ongoing staff comms and public engagement

	• Phase 2 of compound commences and consultant's car park closes		
October 2021	• MCEC build commences	• Major comms campaign to mark the build phase of this project	• Local/national media

8. Framework for communications

- Staff engagement (including partners) - encourage flexible working where possible
- Public engagement (including elected members, neighbours)
- Volunteers engagement
- Signage improved and updated regularly
- Appointment letters and leaflets - encourage the continued use of virtual appointments
- IHP Interface with the staff and public, and sub-contractors
- Trial golf buggies and mobility support for disabled access
- Additional off-site parking for staff: Littledown Centre (& some at Village)
- Continued home working where appropriate
- Additional off site office accommodation options
- Encourage use of sustainable transport (bus, bike etc) to reduce parking/traffic
- Key points of contact / feedback including "real time" responses
- "Considerate contractor" check lists, including when very noisy works happening

9. Integration with Poole Hospital site communications plan

Oct 2020: New Eddie Hawker Access completes. Internal comms with new access arrangements

Nov 2020: Eddie Hawker Access open to staff and patients, parking outside Eddie Hawker ceases

- Launch of Poole Hospital site brochure
- Distribution of local Poole site newsletter for neighbours, with covering letter from chief executive

10. Measurement

The effectiveness of this communications plan will be measured in a number of ways:

- Number of articles appearing in trust publications
- Awareness among staff of the changes (via an on-line survey?)
- Number of visits to the intranet section

The effectiveness of this plan will be reviewed and amended as required.

Appendix: Draft announcement for launch of the enabling works (internal comms only)

Enabling work starts ahead of the building phase for major emergency hospital

Work to create the new major emergency hospital at Royal Bournemouth Hospital is about to begin. In the preparation phase there will be considerable change and disruption. During this phase the Atrium will be closed for the creation of the new main entrance and concourse. The start of these works is enabling works in late January 2021, beginning with the road around the site.

After consideration of several options, the charity team, PALS and volunteers will move into the management area for the 3 years, before they move to their permanent home, back in the main entrance and concourse once the overall project is completed.

Looking further ahead, from late 2024 the whole management area will start to be refurbished and turned into a clinical area. At this point there will need to be another set of office changes as part of a wider review of the whole UHD estate

This project this is part of an overall £250m reorganisation of NHS services across Dorset and will see RBH become the main centre for emergency services and Poole Hospital the main centre for planned treatment.

Richard Renaut, chief strategy and transformation officer, said: “Whilst we understand the disruption these changes will cause, the start of this work is great news as it marks the start of our plans to develop RBH as the major emergency hospital.

“We recognise that this change will affect a number of departments, which is why we’ve made it a priority to give each of them an alternative home in the hospital. During this period disturbances will be kept to a minimum and we thank staff for their support during this period.”

IHP Integrated Health Projects by VINCI CONSTRUCTION Sir Robert McALPINE

NHS University Hospitals Dorset NHS Foundation Trust

Newsletter number 1
November 2020

Investing in Poole Hospital

Welcome to the first edition of our construction newsletter, in which we aim to keep our neighbours and the local community updated on the upcoming construction works at Poole Hospital.

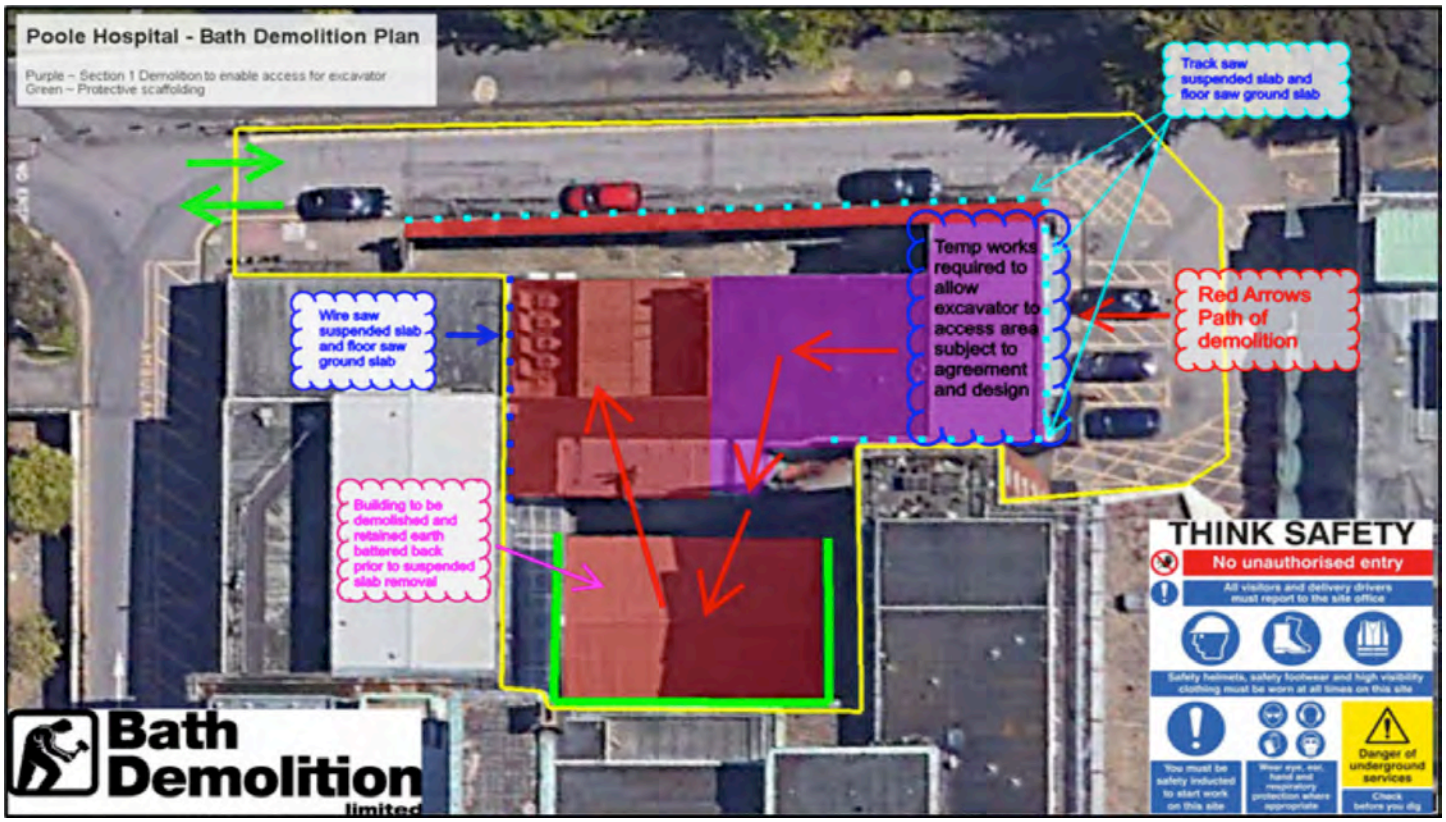
The works will begin November 2020, with overall completion planned for early 2023.

New theatres project: background

This project this is part of an overall £250m reorganisation of NHS services across Dorset and will see Poole Hospital become the main centre for planned treatment.

The scheme will see the construction of a new state-of-the-art theatre complex with 10 new theatres and expanded day case provision, replacing the original theatres built in the 1960s.

The scheme will involve the demolition of existing temporary buildings and extending the existing hospital over five floors. Plan below shows working area and single access in and out of the site.



Developing One NHS in Dorset

CONSIDERATE CONSTRUCTORS

What's happening? November 2020 to January 2021

Existing building to be demolished

Site set up
Boundary and acoustic hoarding, site gates, site offices - ongoing.

Service diversions
Between building interfaces, drainage and access roads at all levels.

Enabling works
Preparation for continue access between buildings and wards with the installation of a covered 'tunnel', and privacy film on windows. Preparation of safe routes for hospital to maintain function.

Demolition
Internal strip out and then removal of main structure, and underground concrete - commencing early 2021 for 15 weeks.

Additional information

Be aware by its nature these works are likely to cause some concern with a normal reaction to unusual noise and vibration. There are many measures are in place to address these including:

- regular communication with Poole Hospital transformation leads, consultants, nursing staff, laboratory and ward managers
- machinery with lower noise levels at source
- sequence for demolition has been undertaken to keep disruption to a minimum
- flexible approach for consultations or activities that require a quieter environment (please let us know via the contact email below or your department leads)
- we will be closely monitoring activities and will endeavour to work safely, with respect to you our neighbours, while maintaining positive progress to the end goal

In our next newsletter we will introduce you to key members of the team, and update you on progress.

University Hospital Dorset - Investing in Poole Hospital

- Developing the major planned care hospital for east Dorset
- State-of-the-art theatre complex
- New Urgent Treatment Centre - open 24/7
- Expanded day case surgery
- Enhanced outpatient, cancer and diagnostic services
- Innovative new community hub.

We apologise for the disruption these building works may cause and thank you for your support. If you have any questions please email:
oneacutenetwork@uhd.nhs.uk

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 November 2020

Agenda item: 10.2

Subject:	Poole 2019/20 Trustee's Report and Accounts

Prepared by:	Linda Strutt, Senior Financial Accountant
Presented by:	Pete Papworth, Chief Finance Officer

Purpose of paper:	To approve the 2019/20 Trustee's Report and Accounts
Background:	The Trustee's Report and Accounts were presented to the Charitable Funds Committee meeting on 6 November 2020 and recommended to the Board of Directors for approval.
Key points for Board members:	The attached 2019/20 Accounts and Trustee's Report have now been audited with an unqualified opinion. Audit report ISA 260 and management representation letter attached. The final audited Accounts and Trustee's Report has to be submitted to the Charity Commission by 31 January 2021.
Options and decisions required:	For approval
Recommendations:	For approval
Next steps:	Following approval the final Accounts and Trustee's Report will be submitted to the Charity Commission and the Management Representation Letter will be signed.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	Not applicable
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
Charitable Funds Committee	6/11/2020

Poole Hospital NHS Foundation Trust Charitable Fund Accounts 2019/20

Trustee's Report

Foreword

The Trustee presents the Charitable Fund Annual Report together with the Audited Financial Statements for the year ended 31 March 2020, which have been prepared in accordance with Section 130 of the Charities Act 2011 and the Charities (Accounts & Reports) Regulations 2008.

Trustee

Poole Hospital NHS Foundation Trust has merged with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust on 1st October 2020 to become University Hospitals Dorset NHS Foundation Trust. This new Foundation Trust is the Corporate Trustee of both the Poole Hospital NHS Foundation Trust charitable fund and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust charitable fund. Poole Hospital NHS Foundation Trust ceased to be the corporate trustee on 30th September 2020. No other aspects of the Charity will change as a result of this.

The new University Hospitals Dorset NHS Foundation Trust will be considering whether it should continue to operate both existing charities or merge the charities to form a single charitable fund in support of the new organisation. At present no decisions have been made in this regard.

The Directors of University Hospitals Dorset NHS Foundation Trust are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee. The Board members who served during the financial year and to the date of signing the financial statements were as follows:

- Debbie Fleming, Chief Executive Officer (from 1 October 2020)
- Alyson O'Donnell, Chief Medical Officer (from 1 October 2020)
- Pete Papworth, Chief Finance Officer (from 1 October 2020)
- Mark Mould, Chief Operating Officer (from 1 October 2020)
- Paula Shobbrook, Chief Nursing Officer (from 1 October 2020)
- Richard Renaut, Chief Strategy and Transformation Officer (from 1 October 2020)
- Karen Allman, Chief People Officer (from 1 October 2020)
- Peter Gill, Chief Informatics and IT Officer (from 1 October 2020)
- David Moss, Chair (from 1 October 2020)
- John Lelliott, Non Executive Director (from 1 October 2020)
- Pankaj Dave, Non Executive Director (from 1 October 2020)
- Cliff Shearman, Non Executive Director (from 1 October 2020)
- Stephen Mount, Non Executive Director (from 1 October 2020)
- Philip Green, Non Executive Director (from 1 October 2020)
- Caroline Tapster, Non Executive Director (from 1 October 2020)
- Christine Hallett, Non Executive Director (from 1 October 2020)

Poole Hospital NHS Foundation Trust Charitable Fund Accounts 2019/20

Trustee's Report

The directors of Poole Hospital NHS Foundation Trust to 30th September 2020 were as follows:

- Mrs. Debbie Fleming – Chief Executive (to 30 September 2020)
- Mr. Mark Mould – Chief Operating Officer and Deputy Chief (to 30 September 2020)
- Mr. Stephen Mount – Non-Executive Director (to 30 September 2020)
- Mrs. Patricia Reid- Director of Nursing (to 30 September 2020)
- Mr. Mark Orchard – Director of Finance (to 30 September 2019)
- Mr. Peter Papworth- Joint Interim Director of Finance (from 1 October 2019 to 30 September 2020)
- Mr. Philip Green – Non-Executive Director (to 30 September 2020)
- Dr. Calum McArthur - Non-Executive Director (to 30 September 2020)
- Mr. David Moss – Chair (to 30 September 2020)
- Mrs. Caroline Tapster - Non-Executive Director (to 30 September 2020)
- Mr. Angus Wood – Medical Director (to 31 December 2019)
- Dr. Matt Thomas- Acting Medical Director (from 1 January 2020 to 30 September 2020)
- Mr. David Walden – Non-Executive Director (to 30 September 2020)
- Mr. Nick Ziebland – Non-Executive Director (to 30 September 2020)

University Hospitals Dorset NHS Foundation Trust (previously Poole Hospital NHS Foundation Trust to 30th September 2020) is the Corporate Trustee of the Charitable Fund governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Acts 2011. The NHS Foundation Trust Board also comprises the Charitable Funds Committee and meets not less than quarterly.

The Charitable Fund is registered with the Charity Commission (no. 1058808) in accordance with the Charities Act 2011.

Reference and Administrative details

The Charity – Poole Hospital NHS Foundation Trust Charitable Fund, registered Charity Number 1058808, was entered on the Central Register of Charities on the 23 October 1996. The Charity is comprised of approximately 143 individual funds as at the 31 March 2020 and the notes to the accounts distinguish the types of fund held and disclose separately all material funds. Charitable funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990.

Trustee's Report

Principal Charitable Fund Adviser to the Board:

The Director of Finance of the Foundation Trust under a scheme of delegated authority approved by the Corporate Trustee, has responsibility for the management of the Charitable Fund. The Financial Services Manager was responsible for overseeing the day to day financial management and accounting for the Charitable Fund during the year.

Principal Office

The principal office for the Charity is:

Finance Department
Poole Hospital
Longfleet Road
Poole
Dorset
BH15 2JB

Corporate Trustee and Parent of Charity

University Hospitals Dorset NHS Foundation Trust (previously Poole Hospital NHS Foundation Trust)
Longfleet Road
Poole
Dorset
BH15 2JB

Principal Professional Advisers:

(a) **Bankers**

Barclays Bank plc. Level 28, 1 Churchill Place, Canary Wharf, London. E14 5HP

CCLA, 80 Cheapside, London EC2V 6DZ

(b) **Solicitors**

DAC Beachcroft LLP, Winton House, St. Peter Street, Winchester, SO23 8BW

(c) **Independent Auditor**

KPMG LLP, Gateway House, Tollgate, Chandlers Ford, SO53 3TG

Trustee's Report

Structure, Governance and Management

The Governing Document of the Charity is in the form of a Trust Deed dated 9 August 1996. The Charity was registered as a single purpose charity with the Charity Commission on 23 October 1996. The Charity administers funds for the provision of patient care and staff welfare at Poole Hospital, with the Foundation Trust Board acting as Corporate Trustee. The Charitable Funds Committee comprises a representative of the Board of University Hospitals Dorset NHS Foundation Trust (previously Poole Hospital NHS Foundation Trust) and meets not less than quarterly.

The charitable funds are divided into the following categories:

- Restricted Funds £6,381k (2018/19 £7,446k) – these funds were donated for specified purposes for a ward or department and the Trustee may only use these funds for the specified purpose. These funds are administered on a day-to-day basis by fund holders in the relevant departments. The Trustee expects these funds, which are often small, to be used actively so as to make the maximum impact on patient care and staff welfare.

- Unrestricted Funds £614k (2018/19 £732k) – these are general funds (including unrestricted funds designated for specific purposes) that may be used at the discretion of the Trustee for any purpose throughout the Hospital. This includes the improvements of quality care for patients, medical and other clinical and staff welfare purposes.

The Charity was established using the model declaration of trust and all funds held on trust as at the date of registration were either part of the unrestricted funds or restricted funds as described above. Subsequent donations and gifts received by the Charity that are attributable to the original funds are added to those fund balances within the existing Charity. Where new funds have been received which have specific restrictions set by the donor, further restricted funds have been established.

The Corporate Trustee fulfills its legal duty by ensuring that funds are spent in accordance with the objects of each fund and by designating funds the Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers and staff.

The charitable funds available for spending are allocated to Care Groups and Specialties within the Foundation Trust's Directorate management structure. For example the charitable funds for the Medical Clinical Care Group, includes restricted funds for Cardiology, Coronary Care and Oncology.

Non-executive directors of the Foundation Trust Board are nominated for appointment by the Foundation Trust's Nominations, Evaluations and Remuneration Committee and then appointed by the Council of Governors.

Trustee's Report

Executive members of the Foundation Trust Board are subject to recruitment by an appointments committee consisting of the Foundation Trust Board's non-executive directors.

The Charity adopts the Institute of Chartered Secretaries and Administrators guidance for the production of an induction pack for newly appointed members of the Foundation Trust Board and Charitable Funds Committee. This pack provides information about the Charity, including the governing document, the Charitable Funds Committee terms of reference, Trustee's Annual Report and Accounts, budgets, policies and minutes, and information about trusteeship, including the Charity Commission booklet CC3, *The Essential Trustee*. The Chair gives new members of the Foundation Trust Board and the Charitable Funds Committee a briefing on the current policies and priorities for the Charitable Fund. A guided tour of the Foundation Trust's facilities and any additional training that their role(s) may require is also offered.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charitable Fund. The Committee is required to:
• Control, manage and monitor the use of the Charity's resources;
• Provide support, guidance and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income;
• Ensure that 'best practice' is followed in the conduct of all its affairs, fulfilling all of its legal responsibilities and
• Ensure that the approved Investment Policy approved by the Foundation Trust Board as Corporate Trustee is adhered to and that performance is continually reviewed.

The accounting records and the day-to-day administration of the funds are dealt with by the Finance Department located at Poole Hospital, Longfleet Road, Poole, Dorset. BH15 2JB.

Risk Management

The major risks to which the Charity is exposed have been identified and considered including – risk of fraud and boundary controls; over commitments by the Charity; loss of investments if banks go into liquidation and the risk of fundraising not achieving the strategic objectives of the Charity. These have been reviewed and systems established to mitigate those risks. The Charity utilises the Internal Audit function for review of the charitable processes and procedures. Audits are conducted periodically and any areas identified are acted upon.

The Charity also maintains a risk register which is reviewed annually by the Charitable Funds Committee acting on behalf of the Corporate Trustee.

Trustee's Report

Income and Expenditure is monitored in total and is compared with the approved plan on a quarterly basis to detect trends as part of the risk management process to avoid unforeseen calls on reserves.

Related Parties

Poole Hospital NHS Foundation Trust was the main beneficiary of the Charity up to 30 September 2020 (University Hospitals Dorset NHS Foundation Trust from 1 October 2020) and was a related party by virtue of being Corporate Trustee of the Charity and the results of the Charity are included in the consolidated financial statements of the Foundation Trust. By working in partnership with the Foundation Trust the charitable funds are used to best effect. When deciding upon the most beneficial way to use charitable funds, the Corporate Trustee has regard to the main activities, objectives, strategies and plans of the Foundation Trust. The Trustee also collaborates with the Royal Voluntary Service (RVS) who raise substantial funds through the shops and trolley service.

Objectives and Strategy

Specifically the objects of the Charity as stated in the Trust Deed are as follows – any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by Poole Hospital (hereinafter referred to as "the objectives"). A 'Mission Statement' has been approved by the Trustee in order to focus on our objectives:

"Through fundraising activities, events and appeals we will further improve the provision of high quality patient care at the cutting edge of technology throughout the Trust."

Making our vision happen involves all our partners, the RVS, staff, patients, carers and the community. We invite you to join us to make this a reality. If you want to know more about how to become involved or to take part in the fundraising or to make a donation please contact the Fundraising Department on 01202 448449.

Annual Review: Our Activities

During the year, the funds continued to support a wide range of charitable and health related activities benefiting both patients and staff. In general they are used to purchase the very varied additional goods and services that the NHS is unable to provide. For example charitable funds were used to purchase much needed medical equipment. The ward charitable funds receive many donations specifically given to thank the nursing staff and these are used for charitable activities that will benefit staff. The charitable funds also enable consultants and other medical staff to attend courses, not funded by the NHS, which will update them on the new ideas and modern techniques in their specialties.

Trustee's Report

As stated in the Reserves Policy below the Charity aims to hold reserves equal to two or three years' annual expenditure and uses this criteria to measure its success in the reporting period. Total expenditure for the year amounted to £2,411k (£1,885 in 2018/19) which represents 29% (£23% in 2018/19) of the opening reserves balance. The Charity has therefore marginally under-achieved its expenditure objectives in the reporting period.

The Poole Hospital Charity General Fund receives donations and legacies that can be used for any charitable purpose relating to the NHS.

Public Benefit

The Corporate Trustee has given due regard to public benefit when planning the Charity's activities, in accordance with Sections G2 and G3 of the Charity Commission's General Guidance on Public Benefit (January 2008).

The paragraphs above set out our activities, achievements and performance during the year, which are directly related to the objects and purposes for which the Charity exists. The Charity achieves its principal objects and purposes through the provision of patient care and staff welfare at Poole Hospital. These benefits are directly related to the aims of the Charity and are fully compliant with Principles 1 and 2 of the Charity Commission Principles on Public Benefit.

Reserves Policy

Most of the expenditure incurred by the Charity is in respect of contributions to capital expenditure developments at Poole Hospital and on patient and staff amenities as and when required. The policy for holding reserves has to be a balance between keeping small amounts of money in individual funds for which specific donations have been given and planning for future major capital investment.

Grants were only made to Poole Hospital NHS Foundation Trust to 30th September 2020 (University Hospitals Dorset NHS Foundation Trust from 1 October 2020) in furtherance of the charitable objects of the Charity. A liability for such grants is recognised when approval has been given by the Trustee and a constructive obligation is created. Contractual arrangements are recognised as goods or services are supplied.

Normally the Trustee would expect to hold reserves equal to two or three years' annual expenditure. Significant legacies and donations are received by the Charity each year and the Charity also engages in fundraising activities to replenish its reserves. This reserves expenditure policy has been marginally under-achieved in the current year.

The Charitable Funds Committee, on behalf of the Corporate Trustee, reviews this policy annually.

Trustee's Report

Our Future Plans

The reconfiguration of services and the plans for redesigning patient care to meet the needs of the future will influence the priorities for spending charitable funds. The Trustee reviews the spending priorities for each fund annually.

In light of the current economic environment, the Trustee has assessed the underlying cost base and existing commitments of the Charity when considering the basis on which to prepare the financial statements. The Trustee has concluded that it has adequate funds to meet the liabilities of the Charity as they fall due for at least 12 months from the date of approval of the financial statements and will only make discretionary grants to the extent that funds are available.
The financial statements have been prepared on a going concern basis which the Trustees consider to be appropriate for the following reasons:

The business model of the Charity is such that its charitable activities are limited to those which it has sufficient funds to support from the excess of funding received over the costs of administering the Charity. The Charity therefore has no specific commitments and no committed costs beyond its fixed costs of operation which are detailed in notes 3.2 and 4.

The Trustee has reviewed the cash flow forecasts for a period of three years from the date of approval of these financial statements which indicate that the Charity will have sufficient funds to meet its liabilities as they fall due for that period. The Trustee has also considered the implications of COVID-19 on these cash flow forecasts and consider that as a result of its operating model explained above, even if no further funding is received in the 12 month period, the Charity has sufficient cash reserves to pay all committed costs.

Consequently the Trustee is confident that the Charity will have sufficient funds to continue to meet its liabilities as they fall due for at least 12 months from the date of approval of the financial statements.

A Review of our Finances, Achievements and Performance

The net assets of the Charitable Funds as at 31 March 2020 were £6,995k (31 March 2019 £8,178k). Overall net assets decreased by £1,183k (2018/19 increase £152k) with unrealised gains on fixed assets of £7k (2018/19 £0k) and a deficit of income over expenditure of £1,183k (2018/19 surplus of £152k). Expenditure incurred during the year was funded by income accumulated over a number of years with the intention of making these purchases.
The Charity continues to rely on donations, legacies and investment income as the main sources of income. The total income in the year was £1,221k (2018/19 £2,037k). Total incoming resources decreased by £816k (2018/19 decrease £175k).

Trustee's Report

Poole Hospital Charity is the major fundraising vehicle of the Charity. Throughout the year numerous events were held, helping to raise funds to purchase equipment for various wards and departments throughout the Hospital.

There has been ongoing media coverage and large fines for some charities that have mishandled the personal data of donors and fundraisers.

- We do not sell the names, addresses or data of any of our supporters.
- We do not share our supporter database with other charities.
- We do not use third party fundraising agencies to sign up donors on the street (known as 'chugging') or to contact donors at their home or place of work.

Poole Hospital Charity is registered with the Fundraising Regulator. The Charity is demonstrating its commitment to good fundraising practice and follows the Code of Fundraising Practice and the Fundraising Promise.

The Charity is also a member of the NHS Charities Together (formerly the Association of NHS Charities) which provides support and information services and sharing of best practice.

Of the total expenditure of £2,411k (2018/19 £1,885k), direct charitable expenditure activity, including support costs, was £2,238k (2018/19 £1,703k) across a range of programmes:

- ***Patient and staff welfare and amenities***
  Patient and staff welfare and amenities expenditure amounted to £2,192k (2018/19 £1,657k). This included - Patient Welfare and Amenities £1,697k (2018/19 £1,493k); Staff Welfare and Amenities £412k (2018/19 £100k) and Miscellaneous £83k (2018/19 £64k).

Resources expended by the Charity during the year are analysed in more detail in Note 4 of the Accounts.

Investments

The Charity aims to spend all funds within a 2-3 year period and the Trustee has therefore decided to invest all of the charitable funds in short term fixed and instant access deposit accounts.

The total bank and cash held at 31 March 2020 was £9,358k (31 March 2019 £8,852k). £4,599k was invested in instant access accounts at COIF. The remaining cash balances are held in instant access accounts at Barclays (£759k); Barclays fixed term deposits (£2,000k) and Lloyds Bank fixed term deposits (£2,000k). Total bank deposit interest earned during the year amounted to £62k (2018/19 £54k).

Trustee's Report

The performance of the investments is continuously monitored. Quarterly performance reports are reviewed by the Charitable Funds Committee.

Responding to the Covid-19 pandemic

The Poole Hospital Heroes Fund, which was set up by the Charity to respond to the health and well-being needs of the hospital's staff and patients during the Covid-19 pandemic, has received to date £170,000 in grants and donations. A wide range of charitable organisations, local businesses and individuals have all contributed to the fund with significant grants received from NHS Charities Together and the Talbot Village Trust, a Charity supporting causes in the Bournemouth, Poole and Christchurch area, to support staff wellbeing initiatives.

Funds received have been used to support staff safe spaces, which offer staff a place to rest and reflect; food and hydration, and the establishment of staff support helplines and counselling services. It has also been used to help patients, particularly those recovering from Covid-19, including funding delirium activity boxes, which include strengthening equipment, puzzles, quiz books, colouring activities, board games and card games, which are being used by the Hospital's respiratory therapy team to aid post-Covid-19 patient rehabilitation.

Looking ahead, the Charity is working to ensure that a lasting legacy remains from the donations which will be used to continue to support patient wellbeing and look after the psychological, physical and mental wellbeing of staff.

A Big Thank You

On behalf of the staff and patients who have benefited from improved services due to donations and legacies, the Corporate Trustee would like to thank all members of the public, organizations, patients, relatives and staff who have made charitable donations. The Charity would also like to thank its volunteers, who provide support relating to fundraising events held in support of our objective.

Approved on behalf of the Corporate Trustee

Debbie Fleming – Chief Executive Officer, University Hospitals Dorset NHS Foundation Trust

xx xxxx 2020

Organisation

CHARITABLE TRUST ACCOUNT - POOLE HOSPITALS NHS TRUST - 2019-20

POOLE HOSPITAL NHS FOUNDATION TRUST CHARITABLE FUND

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2020

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POOLE HOSPITAL NHS FOUNDATION TRUST CHARITABLE FUND

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2020

Foreword to the Financial Statements

FOREWORD

These financial statements have been prepared by the Trustee in accordance with Section 130 of the Charities Act 2011 and the Charities (Accounts and & Reports) Regulations 2008.

STATUTORY BACKGROUND

The Trustee has been appointed under s11 of the NHS and Community Care Act 1990.

Poole Hospital NHS Foundation Trust Charitable Fund is registered with the Charity Commission (Registration Number 1058808).

MAIN PURPOSE OF THE FUNDS HELD ON TRUST

relating to the National Health Service wholly or mainly for the services provided by Poole Hospital NHS Foundation Trust.

POOLE HOSPITAL NHS FOUNDATION TRUST CHARITABLE FUND

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2020

Statement of Trustee's Responsibilities

The Trustee is responsible for preparing the Trustee's Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of resources of the Charity for that period.

In preparing these financial statements, the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed and;
- prepare the financial statements on the going concern basis unless it is inappropriate i.e. that the Charity will continue in business.

The Trustee is responsible for keeping accounting records which disclose with reasonable accuracy the financial position of the Charity and which enable it to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed. The Trustee is also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

By order of the Trustee

Signed: _____

Debbie Fleming – Chief Executive Poole Hospital NHS Foundation Trust

Date: xx Xxxxxxx 2020

POOLE HOSPITAL NHS FOUNDATION TRUST CHARITABLE FUND

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2020

INDEPENDENT AUDITOR'S REPORT TO THE TRUSTEE OF POOLE HOSPITAL NHS FOUNDATION TRUST CHARITABLE FUND CHARITY

Opinion

We have audited the financial statements of Poole Hospital NHS Foundation Trust Charitable Fund ("the Charity") for the year ended 31 March 2020 which comprise the Statement of Financial Activities, the Balance Sheet and related notes, including the accounting policies in note 1.

In our opinion the financial statements:

· give a true and fair view of the state of the Charity's affairs as at 31 March 2020 and of its incoming resources and application of resources for the year then ended;

· have been properly prepared in accordance with UK accounting standards, including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland*; and

· have been properly prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We have been appointed as auditor under section 144 of the Charities Act 2011 (or its predecessors) and report in accordance with regulations made under section 154 of that Act.

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Charity in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

The impact of uncertainties due to the UK exiting the European Union on our audit

Uncertainties related to the effects of Brexit are relevant to understanding our audit of the financial statements. All audits assess and challenge the reasonableness of estimates made by the Trustees and related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Charity's future prospects and performance.

Brexit is one of the most significant economic events for the UK, and at the date of this report its effects are subject to unprecedented levels of uncertainty of outcomes, with the full range of possible effects unknown. We applied a standardised firm-wide approach in response to that uncertainty when assessing the charity's future prospects and performance. However, no audit should be expected to predict the unknowable factors or all possible future implications for a charity and this is particularly the case in relation to Brexit.

Going concern

The Trustees have prepared the financial statements on the going concern basis as they do not intend to liquidate the Charity or to cease its operations, and as they have concluded that the Charity's financial position means that this is realistic. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Trustees' conclusions, we considered the inherent risks to the Charity's business model, including the impact of Brexit, and analysed how those risks might affect the Charity's financial resources or ability to continue operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Charity will continue in operation.

INDEPENDENT AUDITOR'S REPORT TO THE TRUSTEE OF POOLE HOSPITAL NHS FOUNDATION TRUST CHARITABLE FUND CHARITY continued

Other information

The Trustees are responsible for the other information, which comprises the Trustees' Annual Report. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. We are required to report to you if:

- based solely on that work, we have identified material misstatements in the other information; or
- in our opinion, the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements.

We have nothing to report in these respects.

Matters on which we are required to report by exception

Under the Charities Act 2011 we are required to report to you if, in our opinion:

- the Charity has not kept sufficient accounting records; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to report in these respects.

Trustees' responsibilities

As explained more fully in their statement set out on page 2, the Trustees are responsible for: the preparation of financial statements which give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Charity'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 they either intend to liquidate the Charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Charity's Trustees as a body, in accordance with section 144 of the Charities Act 2011 (or its predecessors) and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the Charity's Trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Charity and its Trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Jonathan Brown

for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
66 Queen Square
Bristol
BS1 4DE

Date:

KPMG LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

POOLE HOSPITAL NHS FOUNDATION TRUST CHARITABLE FUND

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2020

Statement of Financial Activities

		2019/20			2018/19		
		Unrestricted	Restricted	All	Unrestricted	Restricted	All
	Note	Funds	Funds	Funds	Funds	Funds	Funds
		Total	Total	Total	Total	Total	Total
		£'000	£'000	£'000	£'000	£'000	£'000
Income from	**3**						
Voluntary Income							
Donations & Legacies	**3.1**	240	667	907	553	1,158	1,711
Total Voluntary Income		**240**	**667**	**907**	553	1,158	**1,711**
Charitable activities	**3.2**	4	209	213	36	189	225
Investment income	**3.3**	5	57	62	2	52	54
Other income	**3.4**	0	39	39	0	47	47
Total income		**249**	**972**	**1,221**	591	1,446	**2,037**
Expenditure on							
Cost of raising funds	**3.2**	161	12	173	164	18	182
Charitable Activities	**4**	482	1,756	2,238	140	1,563	1,703
Total expenditure		**643**	**1,768**	**2,411**	304	1,581	**1,885**
Net deficit for the year before Other Recognised Gains/(Losses)		**(394)**	**(796)**	**(1,190)**	287	(135)	**152**
Other Recognised Gains/(Losses)							
Gross transfer between funds		276	(276)	0	(15)	15	0
Gains on revaluation of own fixed assets	**5**	0	7	7	0	0	0
Net movement in funds		**(118)**	**(1,065)**	**(1,183)**	272	(120)	**152**
Reconciliation of Funds							
Fund balances:							
brought forward at 1 April		732	7,446	8,178	460	7,566	8,026
Fund balances carried forward at 31 March 2020		**614**	**6,381**	**6,995**	732	7,446	**8,178**

All gains and losses recognised in the year are included in the Statement of Financial Activities.

The notes at pages 7 to 19 form part of these financial statements.

Signed:…… on behalf of the Corporate Trustee

Pete Papworth - Director of Finance

Date: xx Xxxxxx 2020

POOLE HOSPITAL NHS FOUNDATION TRUST CHARITABLE FUND

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2020

Balance Sheet

	Note	31 March 2020			31 March 2019		
		Unrestricted Funds Total	**Restricted Funds Total**	**All Funds Total**	Unrestricted Funds Total	Restricted Funds Total	All Funds Total
		£'000	**£'000**	**£'000**	£'000	£'000	£'000
Fixed Assets							
Tangible assets	**5**	0	205	205	0	201	201
Total Fixed Assets		0	**205**	**205**	0	201	**201**
Current Assets							
Debtors	**6**	268	329	597	520	1,155	1,675
Cash at Bank and in Hand	**6**	860	8,498	9,358	257	8,595	8,852
		1,128	**8,827**	**9,955**	777	9,750	**10,527**
Creditors: Amounts falling due within one year	**7**	(514)	(2,651)	(3,165)	(45)	(2,505)	(2,550)
Net Current Assets		**614**	**6,176**	**6,790**	732	7,245	**7,977**
Total Assets less Current Liabilities		**614**	**6,381**	**6,995**	732	7,446	**8,178**
Total Net Assets		**614**	**6,381**	**6,995**	**732**	**7,446**	**8,178**
Total Funds	**8**	**614**	**6,381**	**6,995**	**732**	**7,446**	**8,178**

The notes at pages 7 to 19 form part of these financial statements.

The financial statements on pages 5 to 19 were approved by the Corporate Trustee on xx Xxxxx 2020 and were signed on its behalf by:

Signed:…… on behalf of the Corporate Trustee

Pete Papworth - Director of Finance

Date: xx Xxxxxx 2020

NOTES TO THE FINANCIAL STATEMENTS

1 Accounting Policies

1.1 Basis of preparation

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The financial statements have been prepared under the historic cost convention, with the exception of fixed assets which are included at Modern Equivalent Asset Valuation Basis.

In light of the current economic environment, the Trustee has assessed the underlying cost base and existing commitments of the Charity when considering the basis on which to prepare the financial statements. The Trustee has concluded that it has adequate funds to meet the liabilities of the Charity as they fall due for the for at least 12 months from the date of approval of the financial statements and will only make discretionary grants to the extent that funds are available.

The financial statements have been prepared on a going concern basis which the Trustee considers to be appropriate for the following reasons:

The business model of the Charity is such that its charitable activities are limited to those which it has sufficient funds to support from the excess of funding received over the costs of administering the Charity. The Charity therefore has no specific commitments and no committed costs beyond its fixed costs of operation which are detailed in note s 3.2 and 4 of the Accounts.

The Trustee has reviewed the cash flow forecasts for a period of three years from the date of approval of these financial statements which indicate that the Charity will have sufficient funds to meet its liabilities as they fall due for that period. The Trustee has also considered the implications of COVID-19 on these cash flow forecasts and considers that as a result of its operating model explained above, even if no further funding is received in the 12 month period, the Charity has sufficient cash reserves to pay all committed costs.

Consequently the Trustee is confident that the Charity will have sufficient funds to continue to meet its liabilities as they fall due for at least 12 months from the date of approval of the financial statements.

The particular accounting policies adopted, which have been applied consistently throughout the current and prior year, are described below.

Poole Hospital NHS Foundation Trust Charitable Fund meets the definition of a qualifying entity under FRS 102 and has therefore taken advantage of the disclosure exemptions available to it. Exemptions have been taken in relation to presentation of a cash flow statement. Poole Hospital NHS Foundation Trust Charitable Fund is consolidated in the financial statements of its ultimate parent entity, Poole Hospital NHS Foundation Trust, whose financial statements may be obtained at the link to the consolidation on the following page 8.

NOTES TO THE FINANCIAL STATEMENTS

1.2 Consolidation

Poole Hospital NHS Foundation Trust, Longfleet Road, Poole BH15 2JB is the corporate Trustee to Poole Hospital NHS Foundation Trust Charitable Fund. The Foundation Trust has assessed its relationship to the Charitable Fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Fund and has the ability to affect those returns and other benefits through its power over the fund.

Copies of the 2019/20 consolidated Annual Report and Accounts of the Foundation Trust (which includes details of the principal purposes and activities of the Foundation Trust) can be found on the following link: https://www.poole.nhs.uk/pdf/PH%20annual%20report%20and%20accounts%202019-20%20final.pdf

1.3 Funds structure

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non binding wishes or where the Trustee, at its discretion, has created a fund for a specific purpose.

Where the use of a restricted fund becomes impracticable (e.g. where the terms of a restricted legacy can no longer be achieved) the Trustee may pass a special resolution reclassifying the fund as unrestricted but designated for a specific purpose. The Trustee would attempt to respect the wishes of the donor as far as is reasonably practical.

1.4 Income

All income is recognised once the Charity has entitlement to the resources, it is probable that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

1.5 Income from legacies

All income is recognised gross of expenditure. Legacies are accounted for as incoming resources where the receipt of the legacy is probable and the amount can be measured reliably; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

1.6 Expenditure

Expenditure is recognised when a liability is incurred. Grant commitments are recognised when a constructive obligation arises that result in payment being unavoidable.
Grants are only made to Poole Hospital NHS Foundation Trust in furtherance of the charitable objects of the Charity. A liability for such grants is recognised when approval has been given by the Trustee and a constructive obligation is created. Contractual arrangements are recognised as goods or services are supplied.

1.7 VAT and Taxation

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

The Charity is a registered charity and as such is entitled to certain tax exemptions on income and profits from investments and surpluses on any trading activities carried on in furtherance of the Charity's primary objectives, if these profits and surpluses are applied solely for charitable purposes.

1.8 Costs of raising funds

The costs of generating funds relates to the Fundraising Team of Poole Hospital NHS Foundation Trust.

1.9 Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity and are disclosed in note 4.

1.10 Allocation of overhead and support costs

Overhead and support costs have been apportioned on an appropriate basis between Charitable Activities and Costs of Raising Funds. Once allocation and/or apportionment of overhead and support costs has been made between Charitable Activities and Costs of Raising Funds, the cost attributable to Charitable Activities is apportioned across those activities in proportion to total spend.

1.11 Tangible Fixed Assets

Valuation

The Charity's tangible fixed asset is revalued using professional valuations in accordance with International Accounting Standard 16 every five years. A three yearly interim valuation is also carried out. Additional valuations are carried out as appropriate.

Professional valuations are carried out by the Foundation Trust's appointed external Valuer. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

A full asset valuation was undertaken as at 31st March 2020; and this value, together with indexation applied to buildings in line with the Valuer's advice has been included in the closing Statement of Financial Position.

The valuations are carried out primarily on the basis of Modern Equivalent for specialised operational property and Existing Use Value for non-specialised operational property.

Depreciation

Items of buildings are depreciated over their remaining useful economic lives on a straight line basis. The estimated useful economic life of the Resource Centre is 50 years.

Revaluation and impairment

Increases and decreases in asset values arising from revaluations are reported under Other Recognised Gains/(Losses) in the Statement of Financial Activities.

1.12 Realised and unrealised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later).

1.13 Debtors

Debtors are measured at their recoverable amount.

1.14 Cash at Bank and in Hand

Cash at bank and in hand includes any short term investments with a maturity date of twelve months or less from the date of acquisition or opening the deposit or similar account.

1.15 Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt. Amounts that are owing for more than one year are shown as long term creditors.

1.16 Financial Instruments

Financial reporting standard FRS102 Section 11 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because the Charity relies on legacies and donations as its sole source of income it is not exposed to the degree of financial risk faced by business entities.

The Charity's financial assets and liabilities are valued at amortised cost and these are the only type of financial instrument held.

Market Risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. Market risk comprises three types of risk, where the fair value or future cash flows could fluctuate because of movements in the underlying Interest rate risk, Currency risk; and Price risk

Interest rate risk:

The Charity invests surplus funds with Barclays Bank plc, CCLA (COIF) and Lloyds Bank plc either as short term deposits or fixed term deposits up to 12 months. Therefore the Charity's financial assets and liabilities carry nil or fixed rates of interest and the Charity's income and operating cash-flows are substantially independent of changes in market interest rates.

Currency risk

The Charity's transactions are all undertaken in sterling and so it is not exposed to foreign exchange risk.

Price risk

The Charity is not exposed to price risk.

Credit Risk

Credit risk is the possibility that other parties might fail to pay amounts due to the Charity. Credit risk arises from deposits with banks as well as credit exposures to the Charity debtors. The Charity's cash assets are held with Barclays Bank plc, CCLA (COIF) and Lloyds Bank plc. All cash deposits with these institutions are considered to be zero or very low risk.

The majority of the outstanding debt relates to legacies and donations and is considered to be low risk.

Liquidity risk

Because of the large cash deposits held by the Charity it is not exposed to any significant liquidity risks.

1.17 Critical accounting judgements and key sources of estimation uncertainlty

In the application of the Charity's accounting policies, which are described in note 1 above, the Trustee is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The Trustee does not consider there are any critical judgements or sources of estimation uncertainty requiring disclosure beyond the accounting policies listed above.

2 Related party transactions

Poole Hospital NHS Foundation Trust is the sole beneficiary of the Charity. The Charity has provided funding amounting to £1,302k (excluding commitments) to the Foundation Trust for approved expenditure made on behalf of the Charity. During the year none of the members of the Foundation Trust Board or senior Foundation Trust staff or parties related to them were beneficiaries of the Charity.

Neither the Corporate Trustee nor any member of the Foundation Trust Board has received honoraria, emoluments or expenses in the year and the Trustee has not purchased Trustee indemnity insurance.

Staff members' contracts of employment are with Poole Hospital NHS Foundation Trust and not the Charity.

3 Analysis of income

3.1 Donations & Legacies

	2019/20			2018/19		
	Unrestricted Funds Total	**Restricted Funds Total**	**All Funds Total**	Unrestricted Funds Total	Restricted Funds Total	All Funds Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Voluntary Income						
Donations	67	198	265	67	612	679
Legacies	173	469	642	486	546	1,032
Total Voluntary Income	**240**	**667**	**907**	553	1,158	1,711

3.2 Fundraising

	2019/20			2018/19		
	Unrestricted Funds Total	**Restricted Funds Total**	**All Funds Total**	Unrestricted Funds Total	Restricted Funds Total	All Funds Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Charitable activities						
Fundraising Income - Donations	(7)	197	190	16	167	183
Fundraising Shop Sales	8	0	8	11	0	11
Gift Aid and Other	3	12	15	9	22	31
Total Charitable activities	**4**	**209**	**213**	36	189	225
Costs of raising funds						
Salary Recharge (refer to Note 4.5)	69	7	76	136	9	145
Expenditure	92	5	97	28	9	37
Total Costs of raising funds	**161**	**12**	**173**	164	18	182

3.3 Investment Income

	2019/20			2018/19		
	Unrestricted Funds Total	**Restricted Funds Total**	**All Funds Total**	Unrestricted Funds Total	Restricted Funds Total	All Funds Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Investment income comprised :						
Bank deposit interest	5	57	62	2	52	54
Total investment income	**5**	**57**	**62**	2	52	54

Bank deposit interest includes interest on cash deposits held at CCLA Investment Management Limited (COIF) and fixed term deposits held at Barclays Bank plc and Lloyds Bank plc.

All investments are now held as cash or fixed term bonds.

3.4 Other Income

	2019/20			2018/19		
	Unrestricted Funds Total	**Restricted Funds Total**	**All Funds Total**	Unrestricted Funds Total	Restricted Funds Total	All Funds Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Other income	0	39	39	0	47	47
Total other income	**0**	**39**	**39**	0	47	47

4 Expenditure on Charitable Activities

4.1 Support Costs

	2019/20			2018/19		
	Unrestricted Funds Total £'000	**Restricted Funds Total £'000**	**All Funds Total £'000**	Unrestricted Funds Total £'000	Restricted Funds Total £'000	All Funds Total £'000
External Audit	0	6	6	0	6	6
Financial Services (see Note)	4	36	40	2	38	40
Total Support Costs	**4**	**42**	**46**	2	44	46

Note: Financial Services represents the cost of the administration service provided by Poole Hospital NHS Foundation Trust to the Charity. This includes managerial and accounting services, procurement, administering bank accounts and processing cash, preparing accounts, monthly reporting, completing Charity Commission returns etc. An annual fixed fee is recharged from the Foundation Trust to the Charity for this service and is allocated between restricted and restricted based on the value of these funds.

4.2 Analysis of Charitable Expenditure

The Charity undertook direct charitable activities, mainly to improve patient care and staff welfare and also made available grant support to Poole Hospital NHS Foundation Trust in support of a range of charitable activities. The value of Grants (excluding future commitments) paid to Poole Hospital NHSFT during the year amounted to £1,302k. Funds disbursed represent ongoing activity which is not possible to segment into individual grant awards.

	2019/20			2018/19		
	Unrestricted Funds Total £'000	**Restricted Funds Total £'000**	**All Funds Total £'000**	Unrestricted Funds Total £'000	Restricted Funds Total £'000	All Funds Total £'000
Patients Welfare & Amenities	306	1,391	1,697	140	1,353	1,493
Staff Welfare & Amenities	171	241	412	4	96	100
Miscellaneous	1	82	83	(6)	70	64
Total Charitable Expenditure	**478**	**1,714**	**2,192**	**138**	**1,519**	**1,657**

4.3 Total Expenditure on Charitable Activities Summary

	2019/20			2018/19		
	Unrestricted Funds Total £'000	**Restricted Funds Total £'000**	**All Funds Total £'000**	Unrestricted Funds Total £'000	Restricted Funds Total £'000	All Funds Total £'000
Total Support Costs (above)	4	42	46	2	44	46
Total Charitable Expenditure (above)	478	1,714	2,192	138	1,519	1,657
Total Expenditure on Charitable Activities	**482**	**1,756**	**2,238**	**140**	**1,563**	**1,703**

4.4 Charitable expenditure on direct charitable activities in 2019/20 is broken down as follows:

	2019/20			2018/19		
	Unrestricted Funds Total	**Restricted Funds Total**	**All Funds Total**	Unrestricted Funds Total	Restricted Funds Total	All Funds Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Robert White Fund - Cancer Centre, equipment and services	0	1,300	**1,300**	0	821	821
Eviva Lateral Arm	0	12	**12**	0	0	0
Breast Biopsy Guidance	0	25	**25**	0	0	0
Baby bed with side rails	0	11	**11**	0	0	0
Hospital Trolley	0	11	**11**	0	0	0
Counsellor contribution cancer care	0	23	**23**	0	32	32
Nursing contribution, cancer weekend working.	0	29	**29**	0	27	27
Nursing contribution- Chemo Hub	0	23	**23**	0	21	21
Complementary Therapist	0	12	**12**	0	12	12
Dolphin Restaurant Upgrade	224	0	**224**	0	0	0
Staff changing facilities	161	0	**161**	0	0	0
SLA Somerset Cancer Register	0	0	**0**	0	18	18
Videoconferencing equipment Boardroom 1	0	0	**0**	31	0	31
Scalp Cooling System	0	0	**0**	0	51	51
Prostep Abs System x6	0	0	**0**	0	15	15
Dolphin Restaurant Replacement Chairs	0	0	**0**	30	0	30
Palliative care contribution costs	0	0	**0**	0	13	13
Spring contribution costs	0	0	**0**	0	16	16
Nursing contribution- Healthcare Assistant	0	0	**0**	0	8	8
Counsellor contribution Spring	0	0	**0**	0	6	6
DBSU quiet rooom commitment	0	0	**0**	0	2	2
Somerset Cancer Registry commitment	0	0	**0**	0	37	37
Maternity Delivery Rooms	71	0	**71**	0	54	54
Child Health Safeguarding Nurse	0	0	**0**	24	0	24
Named Midwife for Safeguarding	0	0	**0**	17	0	17
AKI/Sepsis Specialist Nurse	0	0	**0**	38	0	38
HASU Monitoring Equip	0	39	**39**	0	0	0
Video Conference Equipment	0	44	**44**	0	0	0
Other Patients Welfare/Amenities	11	(77)	**(66)**	1	276	277
Other Staff Welfare/Amenities	10	180	**190**	4	96	100
Miscellaneous	1	82	**83**	(7)	14	7
	478	**1,714**	**2,192**	**138**	**1,519**	**1,657**

4.5 Analysis of staff costs

	2019/20	2018/19
	£'000	£'000
Salaries Recharge	76	145

Staff members' contracts of employment are with Poole Hospital NHS Foundation Trust and not the Charity. Costs shown above relate to the recharge of these staff costs by Poole Hospital NHS Foundation Trust.

None of the Trustees (acting on behalf of the corporate trustee) have been paid any remuneration or received any other benefits from an employment with the Charity.

There are no employees who received employee benefits of more than £60,000.

The Charity considers its key management personnel to be the members of the Poole Hospital NHS FT board, acting on behalf of the corporate trustee. Full details of the remuneration of the FT Board is disclosed in the Annual Report and Consolidated Accounts of the FT.

4.6 Auditor's Remuneration

The Trustee appointed KPMG LLP as external auditor of the Charity with effect from 6th April 2018. The professional fees earned by KPMG in the 2019/20 audit of the Charity amounted to £6k including VAT (2018/19 £6k).

5 Tangible Fixed Assets

Freehold Land and Buildings	2019/20 Total £'000
Valuation	
Balance at 1 April 2019	**204**
Revaluations	1
Balance at 31 March 2020	**205**
Depreciation	
Balance at 31 March 2019	3
Depreciation charge for the year	4
Depreciation written off on revaluation	(7)
Total at 31 March 2020	**0**
Net book value at 31 March 2019	**201**
Net book value at 31 March 2020	**205**
Historic cost at 31 March 2020 and 2019	**169**

6 Analysis of current assets

Debtors

	2019/20			2018/19		
	Unrestricted Funds Total	**Restricted Funds Total**	**All Funds Total**	Unrestricted Funds Total	Restricted Funds Total	All Funds Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Amounts falling due within one year:						
Accrued income and interest receivable	268	329	**597**	520	1,155	1,675
Total debtors falling due within one year	**268**	**329**	**597**	520	1,155	1,675

Cash and Cash Equivalents

	2019/20			2018/19		
	Unrestricted Funds Total	**Restricted Funds Total**	**All Funds Total**	Unrestricted Funds Total	Restricted Funds Total	All Funds Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Barclays Bank plc Deposit Clients Premium Account	69	690	**759**	2	65	67
COIF Charity Fund Deposit Account	423	4,176	**4,599**	168	5,617	5,785
Barclays Bank plc Fixed Deposit	184	1,816	**2,000**	29	971	1,000
Lloyds Bank plc Investment	184	1,816	**2,000**	58	1,942	2,000
Total Cash and Cash Equivalents	**860**	**8,498**	**9,358**	257	8,595	8,852

7 Creditors: Amounts falling due within one year

	2019/20			2018/19		
	Unrestricted Funds Total	**Restricted Funds Total**	**All Funds Total**	Unrestricted Funds Total	Restricted Funds Total	All Funds Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Amounts owed to Poole Hospital NHS Foundation Trust	(513)	(2,605)	**(3,118)**	(44)	(2,447)	(2,491)
Other trade creditors	(1)	(46)	**(47)**	(1)	(58)	(59)
Total	**(514)**	**(2,651)**	**(3,165)**	(45)	(2,505)	(2,550)

Amount owing at the year end by the Charity to a related party (Poole Hospital NHS Foundation Trust) is for committed grants.

8 Analysis of Charitable Funds

	2018/19			2019/20			
	Opening Balance	Incoming Resources	Resources Expended (inc. transfers gains/losses)	Closing/Opening Balance	Incoming Resources	Resources Expended (inc. transfers gains/losses)	Closing Balance
	1 April 2018			1 April 2019			31 March 2020
Significant funds	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Unrestricted funds							
Poole Hospital Charity	**228**	617	(179)	**666**	261	(620)	**307**
League of Friends	**232**	(26)	(140)	**66**	(15)	(19)	**32**
Cornelia Suite Ward Fund	**0**	0	0	**0**	2	273	**275**
Total Unrestricted funds	**460**	**591**	**(319)**	**732**	**248**	**(366)**	**614**
Restricted funds							
Cancer Care Fund	**72**	18	(69)	**21**	47	(51)	**17**
Resource Centre	**204**	0	(3)	**201**	0	4	**205**
Dorset Cancer Centre Fund	**172**	39	(49)	**162**	230	(133)	**259**
Spring Fund	**108**	34	(43)	**99**	30	(30)	**99**
Coronary Care	**638**	117	(10)	**745**	92	(7)	**830**
Cancer Day Care Fund	**147**	1	(82)	**66**	1	(28)	**39**
NICU Ward Fund	**17**	28	(7)	**38**	28	(39)	**27**
Sandbanks Ward Fund	**59**	11	(13)	**57**	4	(11)	**50**
Robert White Fund	**5,131**	144	(634)	**4,641**	43	(1,082)	**3,602**
Surgical Robot Fund	**0**	436	(436)	**0**	0	0	**0**
Cornelia Suite Ward Fund (reclassified - see below)	**177**	1	99	**277**	0	(277)	**0**
Ladybird Unit Fund	**53**	41	(14)	**80**	124	(1)	**203**
Gullys Place Fund	**70**	29	(39)	**60**	33	(33)	**60**
Durlston Ward Fund	**57**	24	0	**81**	3	(1)	**83**
Others (127 funds)	**661**	523	(266)	**918**	338	(349)	**907**
Total Restricted funds	**7,566**	**1,446**	**(1,566)**	**7,446**	**973**	**(2,038)**	**6,381**
Total All funds	**8,026**	**2,037**	**(1,885)**	**8,178**	**1,221**	**(2,404)**	**6,995**

Name of fund	
Poole Hospital Charity	Unrestricted fund to assist in the provision of patient care and staff welfare in various wards and departments
League of Friends	Unrestricted general purpose fund inherited from the disbanded Poole Hospital League of Friends Charity (CC No. 269994)
Cornelia Suite Ward Fund	In accordance with the accounting policy outlined in Note 1.3 this fund was reclassified during the year as unresctricted but designated for ward refurbishment throughout the Hospital.
Cancer Care Fund	To assist in the provision of patient care and staff welfare in Cancer Services
Resource Centre	Fixed asset reserve for the Resource Centre which provides information resources for patients
Dorset Cancer Centre Fund	To assist in the provision of patient care and staff welfare in the Dorset Cancer Centre
Spring Fund	To provide support to parents and relatives who have experienced the death of a baby during pregnancy, at or just after birth
Coronary Care	To assist in the provision of patient care and staff welfare in the Coronary Care Unit
Cancer Day Care Fund	To assist in the provision of patient care and staff welfare in Cancer Day Care services
NICU Ward Fund	To assist in the provision of patient care and staff welfare in the NICU Ward
Sandbanks Ward Fund	To assist in the provision of patient care and staff welfare in the Sandbanks Ward
Robert White Trust Fund	To fund the Robert White Cancer Centre and other cancer equipment and services
Surgical Robot Fund	To purchase the Da Vinci robot (DVR) and fund the marginal consumable costs for three years
Ladybird Unit Fund	To assist in the provision of patient care and staff welfare in the Ladybird Unit
Gullys Place Fund	To assist in the provision of end of life care and palliative care for children
Durlston Ward Fund	To assist in the provision of patient care and staff welfare in Durlston Ward
Other Funds	To assist in the provision of patient care and staff welfare in other departments of the Hospital

Post Balance Sheet Events

Poole Hospital NHS Foundation Trust will merge with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust on 1st October 2020 to become University Hospitals Dorset NHS Foundation Trust. This new Foundation Trust will become the Corporate Trustee of both the Poole Hospital NHS Foundation Trust charitable fund and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust charitable fund. No other aspects of the charity will change as a result of this.

The new University Hospitals Dorset NHS Foundation Trust will be considering whether it should continue to operate both existing charities or merge the charities to form a single charitable fund in support of the new organisation. At present no decisions have been made in this regard.

KPMG

External Audit Report

Poole Hospital NHS Foundation Trust Charitable Fund

Year ended 31 March 2020

06 November 2020

Contents

This report is made solely to the Trustee of Poole Hospital NHS Foundation Trust Charitable Fund ('the Charity'), in accordance with the terms of our engagement. It has been released to the Trustee on the basis that this report shall not be copied, referred to or disclosed, in whole (save for the Trustee's own internal purposes) or in part, without our prior written consent. Matters coming to our attention during our audit work have been considered so that we might state to the Trustee those matters we are required to state to the Trustee in this 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 Charity and its Trustee, for our work referable to this report, for this report, or for the opinions we have formed.

Please note that that this report is confidential between the Trustee and this firm. Any disclosure of this report beyond what is permitted above will prejudice this firm's commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If the Trustee receives a request for disclosure of this report under the Freedom of Information Act 2000, having regard to these actionable disclosure restrictions you must let us know and you must not make a disclosure in response to any such request without our prior written consent.

Executive summary

The purpose of this memorandum is to set out the significant issues that came to our attention during the course of the audit of Poole Hospital NHS Foundation Trust Charitable Fund for the year ended 31 March 2020.

Our objective is to use our knowledge of the Charity, gained during our routine audit work, to make useful comments and suggestions for you to consider. However, you will appreciate that our routine audit work is designed to enable us to form opinions on the Charity's financial statements and it should not be relied upon to disclose all irregularities that may exist, nor to disclose errors that are not material to the financial statements and contributions.

Audit conclusions	
✓	— We propose an unqualified audit opinion on the financial statements.
Accounting matters	
✓	— No significant accounting issues arose during the course of our audit. — On 1 October 2020, RBCH NHS FT and Poole NHS FT merged into a newly formed Trust, University Hospital Dorset. We have reviewed the required disclosures to explain this change in trustee within the accounts.
✓	— The charity adopted appropriate accounting policies and the financial statements are in accordance with the disclosure requirements of relevant charities legislation, UK GAAP and the Statement of Recommended Practice.
Auditing matters	
✓	— At the time of drafting this report our work is substantially complete however the following work is still in the process of being completed: – Final review of the Trustee's Report and the accounts.
✓	— No significant audit issues arose during the course of our audit of Poole Hospital NHS Foundation Trust Charitable Fund.
Systems and controls	
✓	— We have not identified any issues in relation to the systems and controls in place at the Charity.
Regulatory and tax matters	
✓	— No significant regulatory or tax matters came to our attention during the course of our normal audit work.

KPMG

Appendices

1. Mandatory communications
2. Audit Independence
3. Schedule of adjusted audit differences

Appendix 1

Mandatory communications

We set out below details of the required communications to the Trustee.

Adjusted audit differences Adjustments made as a result of our audit	Under the requirements of Clarified ISA 260 *Communication of audit matters with those charged with governance*, we are required to report any adjusted audit misstatements arising from our work. Please see appendix 3 for a schedule of all adjusted audit differences.
Unadjusted audit differences Audit differences identified that we do not consider material to our audit opinion	There were no unadjusted audit differences.
Management representation letter Letter issued by the Charity to KPMG prior to audit sign-off	In accordance with ISA 580 Written representations, we request written representations from those charged with governance. Written representations are necessary information we require in connection with the audit of Poole Hospital NHS Foundation Trust Charitable Fund. The draft written representations have been provided to the Trustee.
Related parties	There were no significant matters that arose during the audit in connection with the entity's related parties.
Other matters to report to those charged with governance	There are no other matters that we wish to report to those charged with governance.
Difficulties encountered in performing the audit	There have been no disagreements with management on financial accounting and reporting matters that, if not satisfactorily resolved, would have caused a modification of our auditors' report on the Charity's financial statements. We encountered no fundamental difficulties in dealing with management in performing the audit.
Other comments and recommendations	We note that the Charity adopts a policy of revaluation of its land and buildings, which has resulted in a cumulative revaluation reserve from previous years of £36K. The accounting policy note also states that the land and buildings are valued based on a modern equivalent asset (MEA). While the balance is immaterial, we recommend that the revaluation reserve be shown separately on the face of the statement of financial position, and the policy of revaluation be reviewed to ensure that it continues to be appropriate. Normally MEA valuation is only used where the asset is specialised in nature (e.g. a hospital).

Appendix 2
Audit independence

We confirm that, in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and that the objectivity of the Partner and audit staff is not impaired.

To the Audit Committee members

Assessment of our objectivity and independence as auditor of Poole Hospital NHS Foundation Trust ('the Trust')

Professional ethical standards require us to provide to you at the conclusion of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical Standard. As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

We are satisfied that our general procedures support our independence and objectivity

Independence and objectivity considerations relating to the provision of non-audit services

Summary of fees

We have considered the fees charged by us to the Trust and its affiliates for professional services provided by us during the reporting period. We have detailed the fees charged by us to the company and its related entities for significant professional services provided by us during the reporting period below, as well as the amounts of any future services which have been contracted or where a written proposal has been submitted. Total fees charged by us for the period ended 31 March 2019 can be analysed as follows:

Component of audit (all fees exclude VAT)	
	2019/20
Audit services – statutory audit	
Financial Statements Audit	£5,000
Fee for Charity	**£5,000**

We have not provided any non-audit services during 2019/20.

Appendix 2

Audit independence

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgment, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the Audit Committee of the Trust and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

Yours faithfully

KPMG LLP

Appendix 3

Adjusted Audit Differences

Adjusted audit differences (£m)				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
There are no adjusted and unadjusted audit differences identified				

KPMG

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kpmg.com/app

[Letterhead of Client]

KPMG LLP
66 Queen Square
Bristol
BS1 4BE

[Date]

Dear Jon

This representation letter is provided in connection with your audit of the financial statements of Poole Hospital NHS Foundation Trust Charitable Fund ("the charity"), for the year ended 31 March 2020, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the state of the Charity's affairs as at 31 March 2020 and of its surplus or deficit for the financial year then ended;
ii. whether the financial statements have been properly prepared in accordance with UK Generally Accepted Accounting Practice (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and
iii. whether the financial statements have been prepared in accordance with the Charities Act 2011.

These financial statements comprise the Balance Sheet, the Statement of Financial Activities and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Trustees confirm that the Charity is exempt from the requirement to also prepare consolidated financial statements.

The Trustees confirm that the representations they make in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Trustees confirm that, to the best of their knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing themselves:

Financial statements

1. The Trustees have fulfilled their responsibilities for the preparation of financial statements that:

    i. give a true and fair view of the state of the Charity's affairs as at the end of its financial year and of its surplus or deficit for that financial year;
    ii. have been properly prepared in accordance with UK Generally Accepted Accounting Practice ("UK GAAP") (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and
    iii. have been prepared in accordance with the Charities Act 2011.

    The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Trustees in making accounting estimates, including those measured at fair value, are reasonable.

3. All events subsequent to the date of the financial statements and for which section 32 of FRS 102 requires adjustment or disclosure have been adjusted or disclosed.

Information provided

4. The Trustees have provided you with:

    - access to all information of which they are aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
    - additional information that you have requested from the Trustees for the purpose of the audit; and
    - unrestricted access to persons within the Charity from whom you determined it necessary to obtain audit evidence.

5. All transactions have been recorded in the accounting records and are reflected in the financial statements.

6. The Trustees confirm the following:

    i) The Trustees have disclosed to you the results of their assessment of the risk that the financial statements may be materially misstated as a result of fraud.

    Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

    ii) The Trustees have disclosed to you all information in relation to:

    a) Fraud or suspected fraud that it is aware of and that affects the Charity and involves:
        - management;
        - employees who have significant roles in internal control; or
        - others where the fraud could have a material effect on the financial statements; and

    b) allegations of fraud, or suspected fraud, affecting the Charity's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Trustees acknowledge their responsibility for such internal control as they determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Trustees acknowledge their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

7. The Trustees have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

8. The Trustees have disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with section 21 of FRS 102 all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

9. The Trustees have disclosed to you the identity of the Charity's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with section 33 of FRS 102.

10. The Trustees confirm that:

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the charity's ability to continue as a going concern as required to provide a true and fair view.
    b) No events or circumstances have been identified that may cast significant doubt on the ability of the Charity to continue as a going concern.

Yours sincerely,

[Chair of Trustees]

[Trustee]

Appendix to the Trustees' Representation Letter of Poole Hospital NHS Foundation Trust Charitable Fund ("the charity"): Definitions

Financial Statements

A complete set of financial statements comprises:

- a Balance Sheet as at the end of the period;
- a Statement of Financial Activities for the period; and
- notes, comprising a summary of significant accounting policies and other explanatory information.

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

FRS 102 states that:

Omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or combination of both, could be the determining factor.

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and
b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

Qualifying Entity

A member of a group where the parent of that group prepares publicly available consolidated financial statements which are intended to give a true and fair view (of the assets, liabilities, financial position and profit or loss) and that member is included in the consolidation by means of full consolidation.

Related Party and Related Party Transaction

Related party:

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in FRS 102 as the "reporting entity").

a) A person or a close member of that person's family is related to a reporting entity if that person:
    i. has control or joint control over the reporting entity;
    ii. has significant influence over the reporting entity; or
    iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
b) An entity is related to a reporting entity if any of the following conditions apply:
    i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
    ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
    iii. Both entities are joint ventures of the same third party.
    iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
    v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
    vi. The entity is controlled, or jointly controlled by a person identified in (a).
    vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).
    viii. The entity, or any member of a group of which is is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity.

Related party transaction:

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 November 2020

Agenda item: 10.3

Subject:	Bournemouth Charity 2019/20 Trustee's Report and Accounts

Prepared by:	Chris Hickson, Associate Director of Finance, Gerry Gibson, Head of Financial Accounts, Debbie Anderson, Acting Head of Charity and Pete Papworth, Chief Finance Officer
Presented by:	Pete Papworth, Chief Finance Officer

Purpose of paper:	To approve the 2019/20 Trustee's Report and Accounts
Background:	The Trustee's Report and Accounts were presented to the Charitable Funds Committee meeting on 6 November 2020 and recommended to the Board of Directors for approval.
Key points for Board members:	The attached 2019/20 Accounts and Trustee's Report have now been audited with an unqualified opinion. Audit report ISA 260 and management representation letter attached. The final audited Accounts and Trustee's Report has to be submitted to the Charity Commission by 31 January 2021.
Options and decisions required:	For approval
Recommendations:	For approval
Next steps:	Following approval the final Accounts and Trustee's Report will be submitted to the Charity Commission and the Management Representation Letter will be signed.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	Not applicable
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
Charitable Funds Committee	6/11/2020

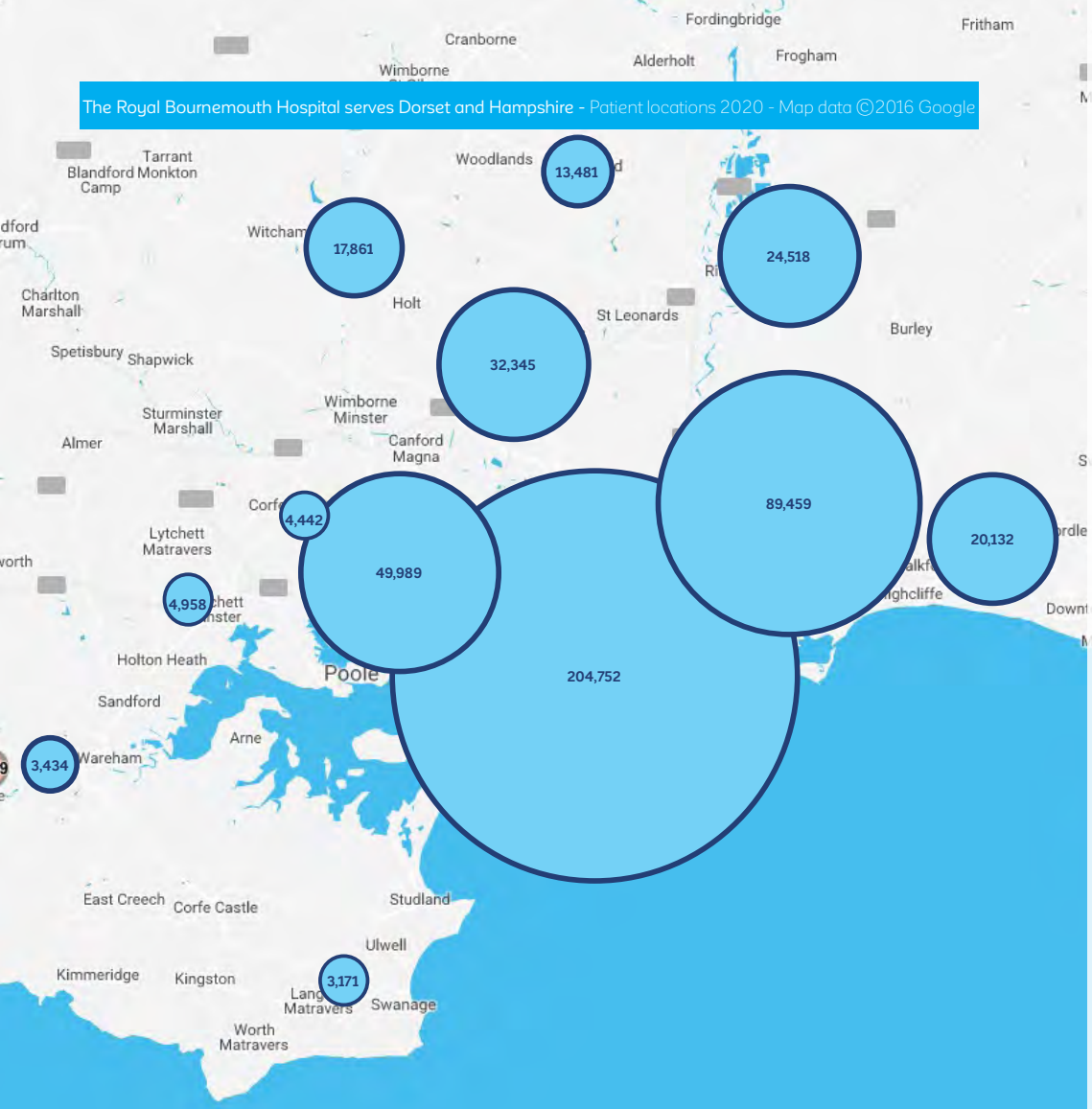
Bournemouth Hospital Charity

Annual Report and Accounts 2019/20

DONATE

FUNDRAISE

VOLUNTEER



Contents:

Chairman's thank you

I am delighted to report another successful year with the Fundraising Team delivering its high level of support across the Trust.

It has been a terrific year for forging strong relationships with departments within the hospital, with a particular focus on the success of launching the 2019/20 Walkerbot campaign in partnership with the Stroke Unit. Within weeks of launching the appeal, the charity received £150,000 from the Alan Miller Estate, making that first crucial step towards our target. The appeal has prompted a number of staff members to involve themselves in the fundraising and has made the charity a more integral part of their workplace; to date staff have organised departmental cake sales, taken on their own fundraising challenges and signed up to our events.

We have seen increasing support from individuals within our community, with increasing donations coming from direct mailing appeals and social media donation buttons. Legacy income has declined, which reflects the current national position across the charity sector and remains difficult to forecast or influence in the short-term.

Our mission remains constant - to enhance the care and treatment of patients accessing NHS services at the Royal Bournemouth and Christchurch Hospitals by fundraising to provide enhanced facilities, state of the art equipment and support NHS staff development to enable the Trust to provide the excellent care we would expect for our own families.

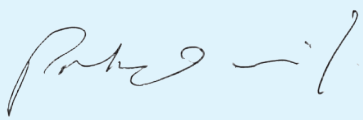
During 2019/20, the charity met its objectives to fund improvements to the hospital environment, whilst also quickly adapting to the fast-changing needs of patients and staff during the global coronavirus pandemic towards the end of March 2020. These improvements included funding a wide variety of non-essential medical equipment to enhance patient care and welfare, and supporting education and training of staff to ensure a well trained workforce and make the Trust a more attractive place to work to support recruitment and retention.

Key pieces of equipment funded include a blue light camera to better diagnose men's health concerns, a digital wide-field imaging system to photograph diseases that manifest in the human eye, and a handheld hCG hormone reader for our Early Pregnancy Unit, to name a few.

The morale of our staff is not only crucial to the patient experience at our hospitals, but also the ongoing welfare of our staff workforce. I am pleased to report that the charity supported training and development for 142 staff alongside the provision of welfare items, including improvements to staff areas, such as providing new coffee machines and microwaves, the refurbishment of the beach huts for staff to bid for and continuing counselling initiatives.

It is inspiring to see our local community coming together to support their hospitals, and hear how many amazing fundraisers have been organised this year. On behalf of the Charitable Funds Committee please accept my sincere and grateful thanks to every family, company, organisation and to all the incredible individuals who have contributed to the charity over the last year. Whether taking part in our annual events such as Twilight Walk for Women, undertaking a physical challenge like our brave China trekkers, making personal donations or leaving a gift in a will; our supporters and donors are at the heart of everything we do. Without their dedication and hard work we would not be able to support the many good projects that assist our hospitals in providing the excellent care we would expect for our families.

Thank you for your loyal and generous support this year, your ongoing support remains vitally important for the future of the Royal Bournemouth and Christchurch hospitals and the patients and staff.



Pankaj Davé

Chairman of the Charitable Funds Committee (2019/2020)

Achievements and performance

Bournemouth Hospital Charity raises funds to enhance the care and treatment of patients accessing NHS services at the Royal Bournemouth and Christchurch Hospitals, by fundraising to provide additional facilities, state-of-the-art equipment and supporting NHS staff development, to enable the Trust to provide the excellent care we would expect for our own families.

The Charity aims to make a difference to every patient and every condition that is treated at our hospitals above and beyond that which can be provided through NHS funding. Money is raised to:

- Enhance patient care and comfort
- Provide state-of-the-art and extra equipment and facilities
- Invest in our experienced staff to support improved patient health and well-being

Working with the community we aim to speed up patient treatment, reduce patient anxiety, aid quicker recovery, provide less intrusive treatment and improve the health and well-being of both patients and staff within the Royal Bournemouth and Christchurch Hospitals.

TOTAL RAISED

£1,386,000

The Charity's income supports service and new equipment across the two hospitals supporting

319,453 outpatients **&** 112,573 inpatients

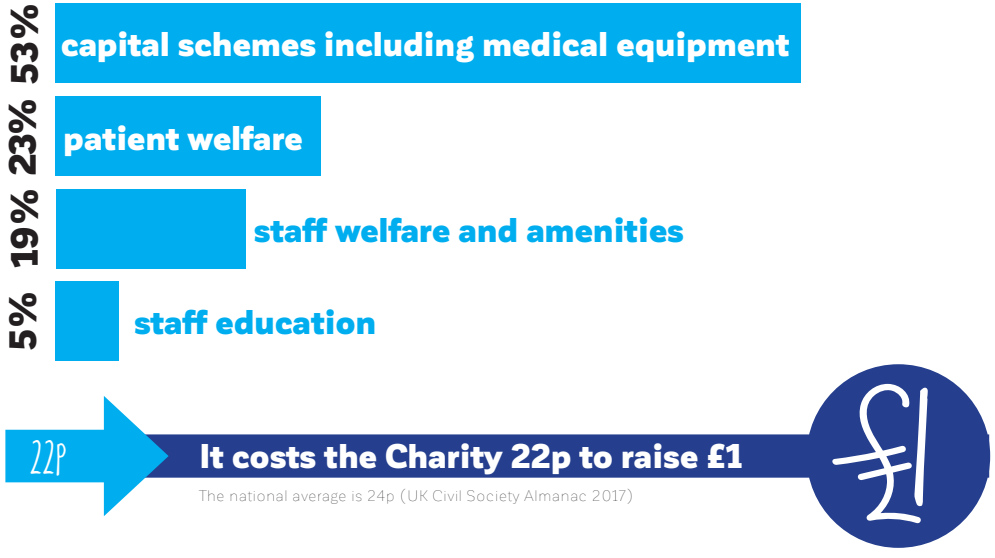
who accessed services during 2019-20

OVER 2900 PEOPLE have been involved in raising funds for the Charity

40 businesses have supported the Charity

82 community groups have supported the Charity

Breakdown of charitable spend:



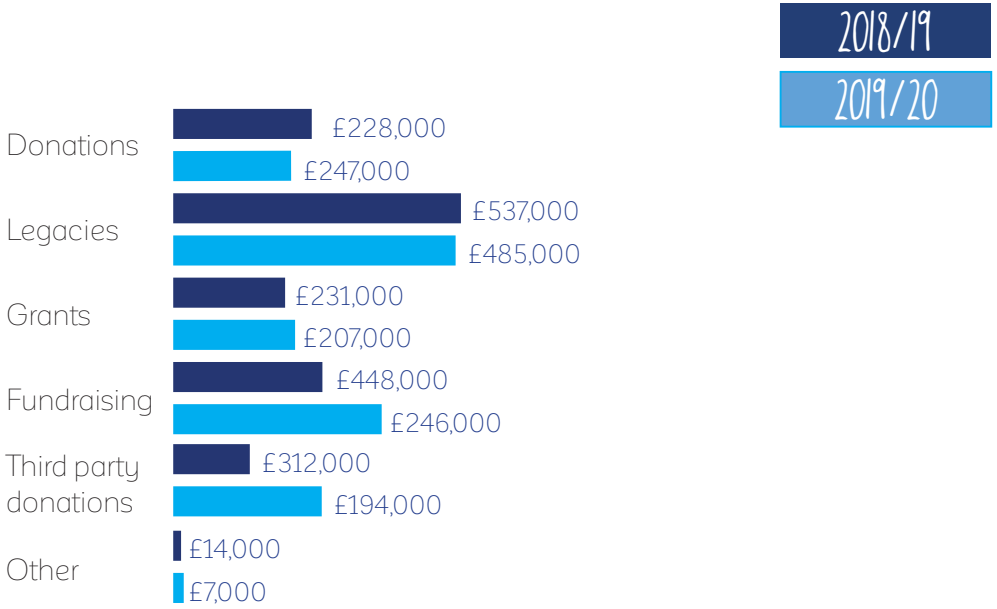
22p **It costs the Charity 22p to raise £1**

The national average is 24p (UK Civil Society Almanac 2017)

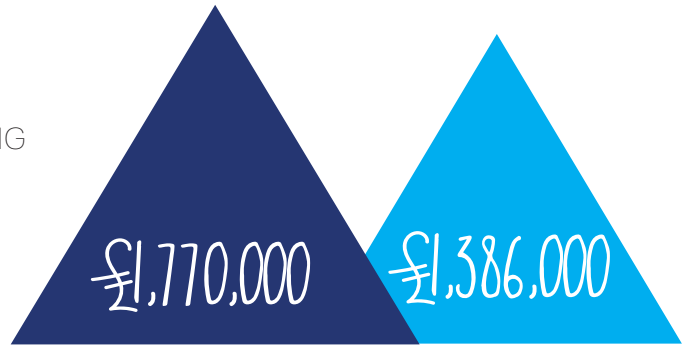
Financial Review

How we raised the income

Our mission is to enhance the care and treatment of patients accessing NHS services at the Royal Bournemouth and Christchurch Hospitals by raising as much money as possible to support the welfare of hospital patients and staff. We continue to raise much needed funds in a variety of ways:



TOTAL INCOMING RESOURCES



Registered Charity no. 1057366

Bournemouth Hospital Charity Annual Report and Accounts

We could not raise this money without all our supporters to whom we are very grateful and extend our thanks:

40 Businesses supported the Charity financially

1,796 Event participants

1,173 Individual donors

82 Community groups have supported the Charity

How we spent the money

This year the charity approved spend of £1.7million to improve care and treatment across both the Royal Bournemouth and Christchurch Hospitals. The Charity seeks to invest in key areas such as providing state of the art medical equipment, providing patient and family support and helping to transform our hospitals into more comfortable, practical and welcoming environments.

Patient benefit

We spent £383,000 on patient benefit projects, including:

Hospedia entertainment – £9,198

Television channels are provided by Hospedia at all bedside TVs. Some services (such as radio) are free but there is a charge for terrestrial and satellite TV access at the hospital. The Charity funded Hospedia access for patients on Ward 11, our long-stay cancer ward, to improve their environment and wellbeing during their stay.

Funding of the patient partner network – £17,880

Our patient communities supplement the face-to-face support provided by clinical teams. This resource saves clinical time and changes the nature of clinical meetings during the pre and post phases. It increases patient confidence and helps them feel more relaxed and knowledgeable about their procedure.

Manual reclining chairs – £2,558

A number of local masonic lodges funded the purchase of four new reclining chairs for patients being treated at the Cardiology department. The chairs will help patients with their recovery and management of their symptoms when visiting the hospital as they allow them to elevate their legs.

Bournemouth Hospital Charity Annual Report and Accounts

Video camera – £5,865

We purchased a new video camera to support patient and staff filming. It is important to film staff around the hospital in order to showcase their expertise, passion for their jobs and highlight the need for fundraising for additional resources, such as specialist equipment and training courses. It also enables a range of up-to-date short films for patients, and their family and friends, to help reduce fears and lead to a better patient experience. The films let patients know what to expect before they come into hospital, introducing them to surroundings and staff.

Staff benefit

We spent £328,000 on staff welfare, training and amenities, some examples:

Beach huts – £5,048

The Charity funds the rental of four beach huts on Bournemouth's beaches, which are available for staff use – all staff can bid for a week through an annual ballot as a thank you for their hard work.

Refreshments

From providing new coffee machines and microwaves, to ice lollies for ward staff during heatwaves and food at staff evening and weekend acuity meetings, we help fuel our staff with extras throughout the year.

Radios and artwork

The Charity has funded radios and artwork for wards and in staff areas to improve the working environment.

Staff training

The Charity is proud to support additional staff training to enhance patient care.

In 2019/20 we supported 142 staff with training and conference attendance.

Advanced Pain and Symptom Management Course – £710

This is the UK's leading course for palliative care nurses, pharmacists, doctors and Allied Health Professionals.

Royal Marsden Gynaecological Cancer Study Day – £230

This course ensures patients are receiving the highest quality, evidence-based care as attendees are kept up to date with evidence base changes. Staff that attended this study day left with an improved knowledge and expertise for caring for this group of patients.

Conferences

29 staff attended a range of 11 conferences, including a mental capacity assessment conference, a pain and opioid conference and an acute medicine conference. Attendance at conferences enhances the workforce skills and knowledge – which is then shared with team colleagues, to ensure staff at the Trust are up to date with the latest developments in medical care.

Equipment

Forus Neo – £50,000

With support from the Alan Miller Estate we were able to purchase a Digital Wide-field Imaging System to allow clinicians to take digital photographs for the documentation of diseases that manifest in the human eye. This piece of equipment is portable and is particularly significant to the Eye Unit as it allows images of the anterior and posterior of premature infants' eyes to be taken with minimal discomfort and distress.

Samsung Digital X-Ray Detector – £31,000

We facilitated the purchase of a 24 x 30cm digital radiography system, which provides advanced low dose imaging experience and streamlines workflow to save more time to focus on improved patient care.

Telecytology machine – £17,418

Grundium Ocus is a mobile digital pathology system that allows remote, high resolution live viewing of histology and cytology slides, as well as whole slide scanning. This is to be used in patients with a cancer diagnosis and by using this equipment as a 'one stop' clinic, staff will be able to diagnose the problem and ensure the patient is on the correct clinical pathway at the earliest possible point.

Wattbike trainer – £4,500

The physiotherapy gym at the Royal Bournemouth Hospital is heavily used by thousands of patients each year. The exercise bikes are one of the most used items of equipment, and it is for this reason that we purchased additional exercise bikes to support the rehabilitation of our patients.

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Reserves policy

Most of the expenditure incurred by the Charity is in respect of contributions to patients, staff and the purchase of medical equipment. The policy of holding reserves is a balance between keeping a relatively small sum of money in individual funds for which specific donations have been made and planning for additional capital investment.

The Trustees considered the reserves policy during 2019/20 and agreed that a minimum reserve of £1million should be retained in unrestricted funds, however with a temporary reserve target of £500,000 recognising the uncertainty in the financial market. This position will be monitored on a regular basis by the Committee.

Fundraising policy

The Trust employs a fundraising team to carry out activities for generating funds; this includes fundraising events, challenges, campaigns and stewarding donors. In addition, proactive marketing is undertaken to maximise all opportunities to raise funds across our local communities for specific projects.

The team also provides guidelines for groups and individuals and monitors fundraising activities on our behalf in the community to ensure that fundraising activities are compliant with relevant legislation.

The Charity is a member of the Fundraising Regulator, which includes the Fundraising Code of Practice and is signed up to the Fundraising Preference scheme. During 2019/20 there has been no failure to comply with these schemes and no material complaints about the Charity's activity.

The Charity has a number of policies which provide additional reassurance regarding our activities and donor care, including an acceptance and refusal of donations policy which highlights that we will treat donors fairly particularly relating to receiving donations from individuals who may be vulnerable.

Excellent donor care and stewardship underpins the fundraising team's activities and approach to proactive fundraising.

Events and Challenges

The fundraising team holds a number of events over the year to raise funds for specific departmental projects – these include our annual mass participation events. These events raise the awareness and profile of the Charity, and in turn increase the number of individual supporters of the Charity.

Events

Twilight Walk 2019

This event attracted over 600 participants, the most we have ever had at an event, who together raised over £23,786 and turned the promenade into a sea of pink in solidarity for women's health despite the torrential rain! The funds raised go towards women's health projects.

Walk for Wards 2019

Our third Walk for Wards event, where participants can raise money for any chosen area of the hospital, was due to take place at the private Somerley Estate near Ringwood on Saturday 26 October. The event was cancelled due to the weather and dangerously high winds. To ensure the hard work of our participants in raising sponsorship did not go to waste, we gave them the opportunity to undertake their chosen distance in their own time and send us pictures. We received photos of our walkers on the beach, at Hengistbury Head and in the New Forest - with some even in fancy dress. By hosting Walk for Wards virtually, we were still able to raise £12,258 for the hopsital's wards and departments.

Light up the Prom 2019

Organised by Bournemouth Hospital Charity, in association with Macmillan Caring Locally, this magical evening of memories, with fireworks and musical entertainment, has become a very popular in memory event in our calendar. Attended annually by thousands of people, this event raises significant funds for the charities involved.

Reindeer Run and Jingle Bell Trail 2019

This new event in our calendar saw us hosting a festive 5km fun run as well as a Christmas themed 1km treasure hunt trail at Avon Heath Country Park. This family-friendly event raised over £3,000 and we look forward to growing it in future years.

Nine Lessons and Carols at Christchurch Priory 2019

Approximately 500 people joined us in the beautiful Christchurch Priory to celebrate the Christmas story. The event enabled the Chaplaincy department to reach past and current patients and connect with the wider community at a reflective time of year.

Challenges

March for Men 2020

Unfortunately due to the coronavirus pandemic, March for Men was cancelled two weeks prior to when it was due to take place. However we are pleased that we still managed to raise £7,147 for men's health projects.

Welsh Three Peaks 2019

In June 2019, eight brave participants successfully took on the Welsh Three Peaks challenge. Starting at 5.30am at Pen-y-Fan, followed by Cadair Iris for a five hour climb and descent, and finishing with the final peak of Snowdon. The whole event took 16 hours, including travel in between. The eight fundraisers raised a tremendous £9,704!

Abseil 2019

In September 2019, 36 participants abseiled down St Peter's Church in Bournemouth to raise money for the Hospital. Collectively they raised an amazing £9,256**!**

The Great Wall of China Challenge 2019

In October 2019, nine participants took on the challenge of trekking the Great Wall of China. Stretching 6,000km, they followed old sections of the Great Wall, as well as restored sections with smooth flagstones and lots of steep steps. Between them they raised £28,130 for a variety of wards and departments around the hospital.

Corporate Supporters

We were delighted to be associated with a number of businesses throughout Dorset which chose to support us through charity partnerships of the year, corporate sponsorship and charity fundraising initiatives during the year. This totalled £35,900 and there has been additional support through gifts in kind, which has increased substantially during the coronavirus pandemic.

Corporate Sponsorship

We received £4,000 in sponsorship for Light Up the Prom. J&Bs Plumbing & Heating Supplies sponsored March for Men and sponsorship was also secured from Coles Miller Solicitors and Laceys Solicitors to provide free Will writing for our Make a Will Month.

Trust and Foundations

We are incredibly grateful to the Trust and Foundations that supported the Charity and the work of the hospital this year with 15 gifts totalling £202,869.

Grateful thanks are due to those companies that chose Bournemouth Hospital Charity as their Charity of the Year including, Humphries Kirk Solicitors, Symonds & Sampson Estate & Lettings Agents, and Chewton Glen Hotel & Spa.

A heartfelt thanks to all those companies that have supported the Charity through fundraising initiatives or specific project fundraising including:

J.P. Morgan
Nisa Local, Westcliff
Halfords
Superior Group Limited
Hertz Accident Support
Haskins Garden Centre
AFC Bournemouth
Barclays Bank
ASDA
Tesco
Churchill Retirement Living

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Community Fundraising

Community fundraising is really important to the Charity; it develops lasting relationships between individual community members, voluntary groups and small businesses, and creates a credible presence locally. This fundraising activity encourages continual involvement with the community that our hospitals serve. This enables organisations to select specific areas in the hospital to support through extra equipment or training to help improve the health and wellbeing of both our patients and staff.

We are grateful to have received in excess of £64,000 from organisations of varying sizes, including a number of schools, Guilds, luncheon clubs, churches, retirement villages, golf clubs and voluntary groups. Their fundraising has included coffee mornings, quiz nights, golf days, raffles and sporting events. Masonic lodges and Rotary clubs have provided significant support during 2019/20 and are linked to funding projects through the Trust.

Bournemouth Male Voice Choir contributed the largest single community donation of £12,500 after they hosted a gala charity concert at The Lighthouse Theatre in Poole.

Staff band, the Volatile Agents held an event in aid of the Charity at the O2 in Boscombe in January, and with a packed venue this raised an incredible £2,691, with match funding from J.P. Morgan of £2,000.

Individual Giving

Every year we are overwhelmed with the support from individuals in our community who choose to support the hospital – often in appreciation of care, whether for themselves or a loved one. From legacies and individual challenges, to donations from direct appeals – we are fortunate to receive hundreds of donations from individuals. It is always humbling to hear the range of personal challenges and sacrifices that people make to support Bournemouth Hospital Charity.

This year people have undertaken a multitude of fundraisers, including head shaves, runs and marathons, bike rides, swims, kayaking, golf days and presents in lieu of significant birthdays, anniversaries and even weddings. Here are just a few of the highlights:

Geoff Jones

Geoff Jones has been an avid supporter of the Charity since our first March for Men event in 2014. Since then he has taken part in March for Men every year and has raised over £10,000 for men's health projects. Geoff continues to fundraise today and in January 2020 he joined other fundraisers to see the blue light camera he helped fund that will better diagnose men's health concerns at the Royal Bournemouth Hospital.

Natasha Hales

Natasha recently raised an incredible £2,932.87 for the Royal Bournemouth Hospital's Breast Care Unit following the treatment her mum received for breast cancer. Natasha raised most of the money by running the Windsor Half Marathon.

Christmas Presents for Patients

In November we sent out a Christmas appeal to ask for donations to buy presents for patients at hospital over the Christmas period. The letter was addressed from Sally, a nurse on Ward 11, and was accompanied with a donation form. In response to our appeal we received 229 donations from supporters, totalling £6,436.

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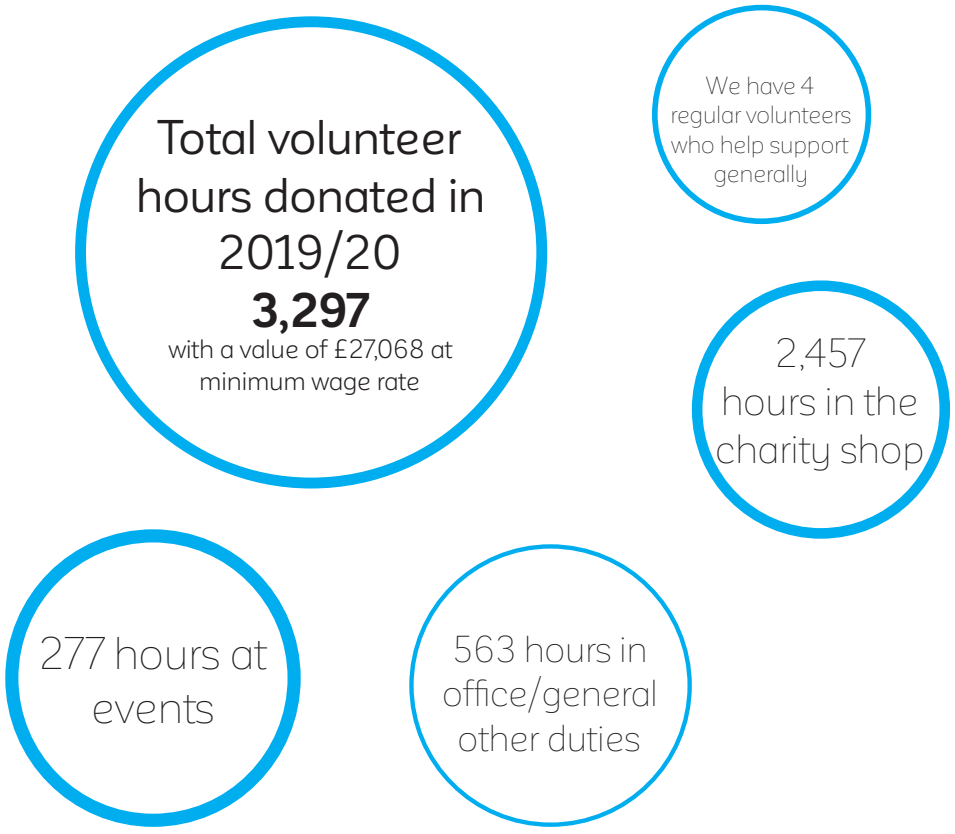
Volunteers

We are extremely fortunate to have a fantastic team of over 200 volunteers who support us with admin tasks in the office, events, and in the Hospital's charity shop. We simply wouldn't make the impact that we do without their generosity and support.

Our volunteers in numbers



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Our volunteers play a vital role as they also act as charity ambassadors in the community, promoting charity events in and outside of the hospital, distributing collection pots, sourcing prizes for raffles and collecting items for our charity appeal shop.

The work they do is invaluable as they are able to reach out to the community in ways charity staff are often unable to.

A number of our volunteers regularly come into the hospital to sell raffle tickets throughout the year. This is an extremely valuable and proactive way of boosting our ticket sales and raising awareness of our work. We rely on volunteers to help at our charity led mass participation events - their involvement is crucial to the success of our events.

We now also have a Volunteer Ward and Department Liaison who has built very positive relationships with a number of wards and departments. This has led to increased staff involvement in both selling raffle tickets to support their departments and participation in our events and challenges.

Our hospital charity shop is open Monday to Friday and provides traditional charity stock of secondhand clothes, shoes, books, knick-knacks, DVDs, jewellery and games/puzzles to visitors to the hospital. Stocked through generous donations from the public, we are indebted to the 14 volunteers who work in the shop and have together raised £31,477 through shop and pop-up sales throughout the year.

The shop also provides an invaluable service to the staff and patients at the hospital, with daily visits from ward clerks and nurses for clothes, shoes and other items for patients who have come to hospital without these. Over the year we responded to 629 requests from staff to provide clothing for patients being treated in our hospital.

This free service is widely known across the hospital with the many wards and services regularly needing clothing for their patients. The type of patient benefiting from this service include mostly elderly, vulnerable and homeless who are admitted as an emergency, unscheduled visit.

The charity shop volunteers like the money they raise to be used predominantly for equipment. They have funded:

- Four anaesthetic trolleys to hold airway and emergency equipment to be used all around the hospital - £6,912
- Two airway simulation training scopes and monitors for anaesthetics. These provide onsite training for staff, identify any latent safety threats and assess current systems - £5,999
- A moleculight handheld device to detect immediate infections in the patient's wound bed - £5,000

Plans for future periods: Objectives for 2020/21

The Bournemouth Hospital Charity has developed a detailed strategy for 5 years from 2016-2021. This provides a framework within which charitable fundraising linked to the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* should be conducted; and how charity money raised is spent to benefit staff and patients within the Trust.

The overarching objective of the Bournemouth Hospital Charity is to raise as much money as possible and ensure its efficient spend to continue to the welfare of both hospital patients and staff.

The Fundraising Strategy provides a framework within which charitable fundraising linked to the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* should be conducted; and how charity money raised is spent to benefit both staff and patients within the Trust.

The main aim for 2020/21 is to continue to maximise charitable income to meet the increasing demands of the Trust – this will depend on the number of identified and agreed flagship projects alongside the fundraising team focusing on excellent stewardship of our existing donors. This is vital to ensure that the Charity remains financially viable and appropriately supports the Trust's vision and mission.

The primary objective of the Charity during 2020/21 is to ensure that the operational implementation of this strategy is delivered, and that charitable income increases in line with the agreed trajectory; for 2020/21 the target is £1.6 million. In order to achieve this, the fundraising team will need continued support from clinical groups across the hospital to ensure suitable projects are identified for fundraising.

The merge with Poole Hospital will require the two charities to merge – managing and implementing this will be a further objective for the charity this year to ensure that the fundraising opportunities continue to be maximised across both sites.

* See page 23

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Additional objectives

In addition to the delivery of the Fundraising Strategy; there are a number of additional objectives that the Charity should focus on, as in previous years:

· Medical equipment – support the requirements of directorates and departments with the funding of non-essential equipment which will enhance patient care and welfare.

· Increased awareness of the charity throughout the Trust to maximise all fundraising opportunities

· Education and Training. Continue to support increased education and training of staff to ensure a well trained workforce and make the Trust a more attractive place to work to support recruitment and retention.

Planned spend of funds

Work will be carried out with the fund holders to ensure that spend plans are in place in line with donors' wishes as appropriate.

In 2019/20 the charity approved spend of

£1.7 million

81% being spent on

medical equipment and direct patient welfare

The balance of 19% was spent on staff welfare, including over 100 applications for specific team and individual training and development to enhance the care provided to our patients. This profile of spend is broadly consistent year on year and it is recommended that:

The Charity aims to maintain this spend with normally no less than 80% on patient benefits, whilst ensuring that donors wishes are followed where donations have specifically been given for staff welfare and appreciation.

Responding to the Covid-19 pandemic

The Bournemouth Hospital Charity NHS Heroes Appeal, which was set up by the Charity to respond to the health and wellbeing needs of the hospital's staff and patients during the Covid-19 pandemic, has received to date £234,000 in grants and donations. A wide range of charitable organisations, local businesses and individuals have all contributed to the fund with significant grants received from NHS Charities Together.

Funds received have been used to support staff safe spaces, which offer staff a place to rest and reflect; food and hydration, and the establishment of staff support helplines and counselling services. It has also been used to help patients, particularly those recovering from Covid-19, including funding whiteboards for patient communication.

Looking ahead, the Charity is working to ensure that a lasting legacy remains from the donations which will be used to continue to support patient wellbeing and look after the psychological, physical and mental wellbeing of staff.

Reference and administrative details

The accounts on which this report is based have been prepared in accordance with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust
deed.

The registered Charity Commission number for the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* Charitable Fund is 1057366.

The registered address is:
The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust
Castle Lane East
Bournemouth
Dorset
BH7 7DW

The Governing Document (dated 17th May 1996) of the charity is in the form of Trust Deeds and has been registered with The Charity Commission. This document encompasses the main objectives of the charity for the provision of patient care and staff welfare at the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*, with the Board of Directors acting as a Trustee. The Trustee is given the authority to efficiently and effectively manage the Charitable Funds.

* See page 23

Bournemouth Hospital Charity Annual Report and Accounts

Trustee

The Royal Bournemouth and Christchurch NHS Foundation Trust has merged with Poole Hospital NHS Foundation Trust on 1st October 2020 to become University Hospitals Dorset NHS Foundation Trust. This new Foundation Trust is the Corporate Trustee of both the Poole Hospital NHS Foundation Trust charitable fund and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust charitable fund. The Royal Bournemouth and Christchurch NHS Foundation Trust ceased to be the corporate trustee on 30th September 2020. No other aspects of the charity will change as a result of this.

The new University Hospitals Dorset NHS Foundation Trust will be considering whether it should continue to operate both existing charities or merge the charities to form a single charitable fund in support of the new organisation. At present no decisions have been made in this regard.

The Directors of University Hospitals Dorset NHS Foundation Trust are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee. The Board members who served during the financial year and to the date of signing the financial statements were as follows:

- Debbie Fleming, Chief Executive Officer (from 1 October 2020)
- Alyson O'Donnell, Chief Medical Officer (from 1 October 2020)
- Pete Papworth, Chief Finance Officer (from 1 October 2020)
- Mark Mould, Chief Operating Officer (from 1 October 2020)
- Paula Shobbrook, Chief Nursing Officer (from 1 October 2020)
- Richard Renaut, Chief Strategy and Transformation Officer (from 1 October 2020)
- Karen Allman, Chief People Officer (from 1 October 2020)
- Peter Gill, Chief Informatics and IT Officer (from 1 October 2020)
- David Moss, Chair (from 1 October 2020)
- John Lelliott, Non Executive Director (from 1 October 2020)
- Pankaj Dave, Non Executive Director (from 1 October 2020)
- Cliff Shearman, Non Executive Director (from 1 October 2020)
- Stephen Mount, Non Executive Director (from 1 October 2020)
- Philip Green, Non Executive Director (from 1 October 2020)
- Caroline Tapster, Non Executive Director (from 1 October 2020)
- Christine Hallett, Non Executive Director (from 1 October 2020)

University Hospitals Dorset NHS Foundation Trust (previously The Royal Bournemouth and Christchurch Hospitals Foundation Trust to 30th September 2020) is the Corporate Trustee of the Charitable Fund governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Acts 2011. The NHS Foundation Trust Board also comprises the Charitable Funds Committee and meets not less than quarterly.

The Charitable Fund is registered with the Charity Commission (no. 1057366) in accordance with the Charities Act 2011.

Related Parties

The Royal Bournemouth and Christchurch Hospitals Foundation Trust was the main beneficiary of the Charity up to 30 September 2020 (University Hospitals Dorset NHS Foundation Trust from 1 October 2020) and was a related party by virtue of being Corporate Trustee of the Charity and the results of the Charity are included in the consolidated financial statements of the Foundation Trust. By working in partnership with the Foundation Trust the charitable funds are used to best effect. When deciding upon the most beneficial way to use charitable funds, the Corporate Trustee has regard to the main activities, objectives, strategies and plans of the Foundation Trust.

Bournemouth Hospital Charity Annual Report and Accounts

Structure, Governance and Management

The charity raises funds that can be accessed and not unreasonably restricted for the benefit of all members of the public. Due regard has been paid to the public benefit guidance published by the Charity Commission.

The Trustee of the Charitable Fund is the Board of Directors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*. The Board of Directors has appointed a Charitable Funds Committee to oversee the arrangements of the charity. This committee monitors the requirements imposed on the Trust by statutory legislation and by the Charity Commission. The committee is also responsible for monitoring the performance of the investments of the charity through its external advisors and approves significant expenditure proposals.

The following were members of the Charitable Funds Committee at the financial year end:

Pankaj Davé
Non-Executive Director and Chair of Committee

Pete Papworth
Chief Finance Officer

Karen Allman
Director of Human Resources

Iain Rawlinson
Non-Executive Director

John Lelliott
Non-Executive Director

Paula Shobbrook, Director of Nursing, stepped down as member on 4 November 2019.

In addition to the voting members, the following attend committee meetings in an advisory capacity:

Chris Hickson
Deputy Director of Finance

Safa Al-Shamma
Consultant Surgeon

Debbie Anderson
Head of Fundraising

Kevin Steele
Governor (replaced Roger Parsons on 6 November 2019)

* See page 23

The Trustee has delegated authorisation of requests for funds based on the following limits:

• Up to £5,000: Authorised Fund Manager.

• Over £5,000: Fund Manager, Business Case Review Panel and Director of Finance.

• Any requests for funds above £20,000 require the additional approval from the Charitable Funds Committee.

• Any requests for medical equipment, regardless of value, must receive approval from the Medical Equipment Committee in addition to the financial approvals above.

The Trustee has agreed that The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* will provide administrative support to the charitable funds. This takes the form of managerial and accounting services, financial monitoring and advice. An annual fixed sum is recharged, together with actual fundraising costs incurred throughout the year.

Charity Committee Members Induction and Training

Non-executive directors of the Board of Directors are appointed by the Council of Governors. The chief executive is appointed by the non-executive directors, subject to the approval of the Council of Governors. Executive directors of the board are appointed by a committee, normally comprising the chairman, the chief executive, at least two other nonexecutive directors and an independent assessor, to be approved by the Board of Directors. Members of the Board of Directors and the Charitable Funds Committee are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee.

The Charity provides, in collaboration with the NHS Foundation Trust*, an induction pack for newly appointed members of the NHS Board of Directors and Charity Trustee Committee. As part of their induction programme, new executive and non-executive directors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* are made aware of their responsibilities as Board members of the Corporate Trustee of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* Charitable Fund.

All executive and non-executive directors are invited to attend core induction and diversity training programmes. A guided tour of the beneficiary NHS Foundation Trust's* facilities and any additional training that their role(s) may require is also offered. The chair of the Charity Committee gives new members of the Charitable Funds Committee a briefing on the current policies and priorities of the charitable funds. This induction includes an introduction to the objectives, scope and policies of the Charitable Funds, member responsibilities and a copy of the latest Charity Annual Accounts and Trustee Annual Report.

* See page 23

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The Trustee employed the following professional advisors during the year:

a) Bankers: Barclays Bank, London
b) Solicitors: Beachcroft LLP, Bristol
c) Independent Auditor: KPMG, Bristol
d) Investment Managers: Quilter Cheviot, Bristol

A full set of Annual Accounts relating to Charitable Funds held on Trust for the year ended 31 March 2019 are included in this report.

The Royal Bournemouth and Christchurch Hospitals website can be found at: www.rbch.nhs.uk

The Bournemouth Hospital Charity website can be found at: www.BHcharity.org.uk

Risk Management

The major risks to which the Charity is exposed have been identified and considered by the Trustee. Key risks include increased local competition; the current economic climate; adverse publicity; and a potential fall in the value of investments.

A five year Strategy was approved in 2016 to actively mitigate these risks; and where appropriate, systems, policies and procedures have been established to mitigate specific risks. The Trustee is confident that reliance can be placed upon the management arrangements in place, which include internal and external audit services, to minimise any risk to the funds.

The most significant risk identified is the possibility of losses from a fall in the value of investments and the level of reserves available to mitigate the impact of such losses. Investments are held by qualified and experienced Investment Fund Managers who act in accordance with the agreed Investment Policy. These investments are subject to regular review, with unrealised gains and losses allocated to funds at agreed intervals.

Procedures are in place to ensure that financial commitments remain affordable within the fund balance. Income and expenditure are covered by the Trusts standing financial instructions and there is an agreed recognition criteria in place for the receipt of donations.

There are clear approval procedures in place which give the Corporate Trustee confidence that expenditure will remain in line with the limits of the charities resources, ensuring continued compliance with the agreed reserves policy.

National Health Service
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Charitable Funds

Annual Accounts 2019-20

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Introduction

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* Charitable Fund, was entered on the Central Register of Charities on 06 August 1996.

The charitable funds are registered with the Charity Commission (Charity Number 1057366) in accordance with the Charities Act 2011.

The Board of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* is the Corporate Trustee of the charitable funds governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011.

Members of the Board of Directors are not individual Trustees under Charity Law but act as agents on behalf of the Corporate Trustee.

Main purpose of the funds held on trust

The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the National Health Service, wholly or mainly for the services provided by the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*.

* See page 23

Executive Summary

The year ended 31 March 2020 was a successful year for the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* charitable funds in the current market conditions.

The charitable funds had total incoming resources amounting to £1,386k (2018/19: £1,770k). This includes legacies bequeathed totalling £485k (2018/19: £537k), donations of £247k (2018/19: £228k) and investment income of £6k (2018/19: £4k). The charitable funds also received £440k (2018/19: £760k) from other trading activities and £208k (2018/19 : £231k) from other income. These fundraising events help raise the profile of the Hospitals in the local community.

Resources expended in 2019/20 totalled £1,091k (2018/19: £2,230), of which £383k (2018/19: £340k) related to patient welfare, £328k (2018/19: £204k) to staff welfare and amenities. A decrease in commitments of £983k (2018/19: increase of £952k) is included, and further details on the expenditure for the year can be found in the Annual Report 2019/20.

For 2019/20, the investments portfolio decreased by £219k (2018/19: £144k increase) and other losses of £19k. The charitable funds increased overall by £57k (2018/19: decreased by £316k) leaving a closing balance of £3,414k (2018/19: £3,357). The Financial Report is set out in two parts: the Annual Report followed by the Financial Statements, which include the Notes to the Accounts.

Charitable expenditure is of paramount importance in the continuation of the high quality service offered to our patients, and also assists staff in their working lives.

The Trustee wishes to thank all patients, relatives, staff, volunteers and supporters whose energy and dedication has enabled us to achieve our charitable objectives.

Date:

Pete Papworth

Chief Finance Officer

* See page 23

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Statement of Trustees responsibilities in respect of the Trustees' Annual Report and the financial statements

Under the trust deed and charity law, the trustees are responsible for preparing the Trustees' Annual Report and the financial statements in accordance with applicable law and regulations. The trustees have elected to prepare the financial statements in accordance with UK Accounting Standards, including *FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland*.

The financial statements are required by law to give a true and fair view of the state of affairs of the Charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustees:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards and the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements;
- assess the Charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they either intend to liquidate the Charity or to cease operations, or have no realistic alternative but to do so.

The trustees are required to act in accordance with the trust deed of the Charity, within the framework of trust law. They are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the Charity at that time, and to enable the trustees to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. They are responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the Charity and to prevent and detect fraud and other irregularities.

Date:

John Lelliott - Non-Executive Director

Chairman of the Charitable Funds Committee

Date:

Pete Papworth - Chief Finance Officer

Member of the Charitable Funds Committee

Independent auditor's report to the Trustees of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* Charitable Fund

Opinion

We have audited the financial statements of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund ("the charity") for the year ended 31 March 2020 which comprise the Statement of Financial Activities, the Balance Sheet and related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2020 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with UK accounting standards, including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland; and
- have been properly prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We have been appointed as auditor under section 144 of the Charities Act 2011 (or its predecessors) and report in accordance with regulations made under section 154 of that Act.

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the charity in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The trustees have prepared the financial statements on the going concern basis as they do not intend to liquidate the charity or to cease its operations, and as they have concluded that the charity's financial position means that this is realistic. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the trustees' conclusions, we considered the inherent risks to the charity's business model, including the impact of Brexit, and analysed how those risks might affect the charity's financial resources or ability to continue operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the charity will continue in operation.

* See page 23

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Other information

The trustees are responsible for the other information, which comprises the Trustees' Annual Report. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. We are required to report to you if:

- based solely on that work, we have identified material misstatements in the other information; or
- in our opinion, the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements.

We have nothing to report in these respects.

Matters on which we are required to report by exception

Under the Charities Act 2011 we are required to report to you if, in our opinion:

- the charity has not kept sufficient accounting records; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to report in these respects.

Trustees' responsibilities

As explained more fully in their statement set out on page 31, the trustees are responsible for: the preparation of financial statements which give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the charity'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 they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

The purpose of our audit work and to whom we owe our responsibilities
This report is made solely to the charity's trustees as a body, in accordance with section 144 of the Charities Act 2011 (or its predecessors) and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Jonathan Brown - for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

KPMG LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

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Statement of Financial Activities for the year ended 31 March 2020

	Notes	Unrestricted Funds	Restricted Funds	**2019-20 Total Funds**	2018-19 Total Funds
		£000	£000	**£000**	£000
Income and Endowments from:					
Donations and legacies	2.2	461	271	**732**	**765**
Charitable activities	2.2	296	144	**440**	**760**
Investments	8.4	5	1	**6**	**4**
Other	2.2	154	54	**208**	**241**
Total		916	470	**1,386**	**1,770**
Expenditure on:					
Raising funds	3.1	(379)	(5)	**(384)**	**(380)**
Other	3.2	(490)	(217)	**(707)**	**(1,850)**
Total		(869)	(222)	**(1,091)**	**(2,230)**
Net (losses) / gains on investments	8.1	(219)	-	**(219)**	144
Net expenditure		(172)	248	**76**	**(316)**
Other recognised gains / (losses):					
Other losses	8.3	(19)	-	**(19)**	**-**
Net movement in funds		(191)	248	**57**	**(316)**
Reconciliation of funds:					
Total funds brought forward	11.1	871	2,486	**3,357**	**3,673**
Total funds carried forward		680	2,734	**3,414**	**3,357**

The notes on pages 37-55 form part of these accounts.

Balance Sheet as at 31 March 2020

	Notes	Unrestricted Funds	Restricted Funds	**Total at 31 March 2020**	Total at 31 March 2019
Fixed Assets		£000	£000	**£000**	£000
Investments	8.1	3,990		**3,990**	4,209
Total Fixed Assets		3,990		**3,990**	4,209
Current Assets					
Debtors	9	75	-	**75**	101
Short term investments and deposits	8.3	47	-	**47**	66
Cash at bank and in hand		(2,056)	2,734	**678**	963
Total Current Assets		(1,934)	2,734	**800**	**1,130**
Creditors: Amounts falling due within one year	10	(1,376)	-	**(1,376)**	(1,982)
Net Current Liabilities		(3,310)	2,734	**(576)**	**(852)**
Total Assets less Current Liabilities		680	2,734	**3,414**	**3,357**
Total Net Assets		680	2,734	**3,414**	**3,357**
Funds of the Charity					
Unrestricted		680	-	**680**	871
Restricted		-	2,734	**2,734**	2,486
Total Funds	11.1	680	2,734	**3,414**	3,357

Date:

Date:

John Lelliott
Chairman of the Charitable Funds Committee

Pete Papworth
Chief Finance Officer

Notes to the Accounts

Accounting Policies 1

1.1 Basis of Preparation

The financial statements have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant notes to these accounts. The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011. The trust constitutes a public benefit entity as defined by FRS 102. The trustees consider that there are no material uncertainties about the Trust's ability to continue as a going concern.

In these financial statements the Charity is considered to be a qualifying entity (for the purpose of FRS 102) and has applied the exemption available under FRS 102 in respect of the requirement to present a cash flow statement.

a) Parent entity
The Charity is a subsidiary of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH FT)*, whose main place of business is at Royal Bournemouth Hospital, Castle Lane East, Bournemouth BH7 7DW, and whose principal purpose is the provision of healthcare. The Board of Directors of RBCH FT* is the Corporate Trustee of the charity. The consolidated group accounts, which include the Charity, are available on the RBCH website.

1.2 Incoming Resources

a) All incoming resources are recognised once the charity has entitlement to the resources, it is probable that the resources will be received and the monetary value of the incoming resources can be measured with sufficient reliability (Note 2).

b) Intangible income
The charity had no intangible income/expenditure during the year.

c) Legacies
Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably probable. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred, and once all conditions attached to the legacy have been fulfilled.

Material legacies which have been notified but not recognised as incoming resources in the Statement of Financial Activities are disclosed in a separate note to the accounts, with an estimate of the amount receivable (Note 12).

d) Debtors
Debtors are recognised when a legal or constructive obligation to pay is created, the amount can be measured reliably and it is probable that payment will be received. (Note 9).

* See page 23

1.3 Resources Expended & Arrangements with RBCH Staff

Liabilities are recognised as expenditure as soon as there is a legal or constructive obligation committing the Charity to that expenditure, it is probable that settlement will be required and the amount of the obligation can be measured reliably

a) Cost of generating funds

The cost of generating funds includes all costs associated with generating income for the funds held on trust.

The Trust fundraising team continues to organise fundraising, and provides the opportunity to increase income. The costs associated with fundraising, and the overhead facility costs, are recharged from the Royal Bournemouth (RBH) and Christchurch (XCH) Hospitals NHS Foundation Trust* on an accruals basis, based on actual costs incurred.

b) Grants payable

Grants payable are payments made to third parties (including NHS bodies) in the furtherance of the Trust's charitable objectives of the provision of patient care and staff welfare.

They are accounted for on an accruals basis where the conditions for their payment have been met, or where a third party has a reasonable expectation that they will receive the grant. This includes grants paid to NHS bodies.

c) Management and administrative costs

Service provision for financial information support has been agreed. Associated costs are accounted for on an accruals basis and are recorded as recharges of appropriate proportions from the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*. The recharge for 2019/20 totalled £61,311 (2018/19 £55,356)

The recharge is made up as follows:

Financial Services :	**2019/20**	2018/19
	£000	£000
RBCH Staff	**20**	18
Internal Audit	**2**	2
External Audit	**5**	5
Non Pay Costs	**8**	7
Ext NHS Finance Services	**25**	22
Indemnity insurance	**1**	1
Total	**61**	55

* See page 23

Bournemouth Hospital Charity Annual Report and Accounts

Fundraising costs are also recharged to the charity from the Foundation Trust* and are detailed below:

RBCH Staff	**2019/20**	2018/19
	£000	£000
Pay	**306**	350
Non-Pay	**78**	30
Total	**384**	380

d) Staffing

The Charity has no employees.

1.4 Structure of funds

The funds are classified and structured as below :

Unrestricted Funds

A majority of the charitable funds are unrestricted in their classification. They are "earmarked" unrestricted funds, which are classified into individual areas to be used for a particular purpose in the future. The use of these funds is at the discretion of the Trustee to benefit both patients and staff in their use within a specified area of the Hospitals.

Restricted Funds

The Jigsaw New Build, Orchard Garden, Charities Office, March for Men, Twilight Fund, Christchurch Refurb, Sustain and Walkerbot Appeal are restricted income funds that are expendable at the discretion of the Trustee, in furtherance of some particular aspect(s) of the objectives of the charity which are in line with the donor's wishes.

These funds have arisen from income generated, and are for use by the fund managers to benefit the area specified in the Appeal's purpose. The funds must be utilised in line with the specified purpose.

The Trust has no Endowment (Capital - Expendable or Permanent) Funds.

Analysis of the unrestricted and restricted funds can be found in Notes 11.1 &11.2.

Details of the funds and their individual purpose can be obtained from the Annual Report along with information on the fund performance for the year.

1.5 Fixed Asset Investment

Investment Fixed Assets are shown at Market Value, as detailed in Note 8 to the Statement of Financial Activities.

The Trustee policy is to invest charitable funds with investments that maximise capital and are the most suitable investment type. The long-term objective is to invest capital that will give the maximum growth on income with minimal risk. The investment held as at balance sheet date are units within a Common Investment Fund, and are included in the Balance Sheet at the closing price at 31st March 2020.

* See page 23

1.6 Investment gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or value at date of purchase if later).

Unrealised gains and losses are calculated as the difference between the closing market value and the opening value (or value at date of purchase if later). These are shown in the Statement of Financial Activities under gains on revaluation of investment assets.

Analysis of the Investment gains and losses can be found in Note 8 to the Statement of Financial Activities.

1.7 (Fixed) Short Term Investments

This is interest received on the main bank accounts .

Short Term Investments include stocks and equities that have been received as part of legacies made to the Charitable Funds. These are revalued at year end, and any gain or loss on revaluation of the investment asset is shown in the Statement of Financial Activities.

1.8 Apportionment of Investment Income

The Fixed Asset Investment (Common Investment Fund) is revalued every month, and any unrealised gains or losses on the difference between the closing balance and the opening balance are apportioned over the funds (excluding Restricted).

1.9 Pension Contributions

The charity has no employees, and therefore makes no contributions to any pension fund.

1.10 Prior Year Adjustments

There were some prior year 18/19 adjustments, which have been re-stated and are reflected within the 19/20 accounts.

1.11 Pooling Scheme

An official pooling scheme was registered for investments with the Charity Commission on 16th June 1998.

1.12 Related Party Transactions

The charity has made revenue and capital payments to the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*, whose Board of Directors is the Corporate Trustee of the charity. A summary of the turnover and net surplus for the NHS Foundation Trust* for 2018-19 and 2019-20 is shown in Note 15.

* See page 23

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Arrangements are in place with the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* for the completion of a monthly recharge relating to all charitable expenditure incurred by the Trust. The recharge is paid in arrears.

Details of resources expended with related parties during the year are shown in Note 3.2.
As at 31st March 2020, the Charity owed £647,901 to the Trust.

1.13 Reserves Policy

Most of the expenditure incurred by the Charity is in respect of contributions to patients, staff and the purchase of medical equipment. The policy of holding reserves is a balance between keeping a relatively small sum of money in individual funds for which specific donations have been made and planning for additional capital investment. The Trustees considered the reserves policy during 2019 and agreed that a minimum reserve of £1million should be retained in unrestricted funds, however with a temporary reserve target of £500,000 recognising the uncertainty in the financial markets.

1.14 Supporters

Organisations recognised as major supporters to the Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust* Charitable Funds are as follows:

- The League of Friends of Christchurch Hospital
- Friends of the Bournemouth Eye Unit
- Sustain
- Talbot Village Trust
- Bournemouth Leukaemia Fund
- Valerie Besson Will Trust
- Going for Bust
- Pears #iWill Fund
- Morrisons Foundation

1.15 Third Party Recharges

Income and expenditure relating to Third Party Recharges are included in “Other” within Incoming Resources, and expenditure is included within Grants Payable. Details of all Third Party Recharges during the year are shown in Note 2.3.

1.16 Trustee Remuneration

There have been no payments made during the year for the refund of expenses or remuneration to the Trustee.

1.17 Donations Policy

Donations are receipted to the donor as they are received. All donations are allocated to the specified fund, as stated by the donor. Any restrictions on donations usage are adhered to by the Fund Managers, and the funds are classified accordingly.

* See page 23

Further details of the purposes of various funds can be seen within the Annual Report.

1.18 Activities in Furtherance of Charity Objectives

In the furtherance of Charity objectives, events have been held throughout the year by the fundraising office to generate income to the charitable funds.

Income from the fundraising events held can be seen within Operating Activities for generating funds (see Note 2.1). All related expenditure to these fundraising events has been included within costs of generating funds and can be separately seen on the Statement of Financial Activities for the year.

1.19 Post Balance Sheet Events

Poole Hospital NHS Foundation Trust will merge with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* on 1st October 2020 to become University Hospitals Dorset NHS Foundation Trust. This new Foundation Trust will become the Corporate Trustee of both the Poole Hospital NHS Foundation Trust charitable fund and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust* charitable fund. No other aspects of the charity will change as a result of this.

The new University Hospitals Dorset NHS Foundation Trust will be considering whether it should continue to operate both existing charities or merge the charities to form a single charitable fund in support of the new organisation. At present no decisions have been made in this regard.

1.20 Support Cost, Governance Cost and Cost of Generating Funds Apportionment to Trust Fund

The methodology is to apportion fundraising and adminstration recharges, together with investment gains and losses across all fund balances (excluding restricted funds).

* See page 23

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1.21 Support Cost, Governance Cost and Cost of Generating Funds Apportionment to Expense Type

Consistent with the methodology for apportioning costs to funds, the apportionment of costs to expense type excludes restricted funds.

2019-20	Unrestricted Funds	Governance Costs	**Total Unrestricted**
	£000	£000	**£000**
Patient welfare and amenities	365	52	**417**
Staff welfare and amenities	322	46	**368**
Contributions to NHS	804	115	**919**
Miscellaneous	(51)	(7)	**(58)**
End of Year Commitments	(1,011)	(145)	**(1,156)**
Governance Costs	61	(61)	**-**
Total	490	-	**490**

2018-19	Unrestricted Funds	Governance Costs	**Total Unrestricted**
	£000	£000	**£000**
Patient welfare and amenities	289	9	**298**
Staff welfare and amenities	197	6	**203**
Contributions to NHS	733	7	**740**
Miscellaneous	91	3	**94**
End of Year Commitments	438	30	**468**
Governance Costs	55	(55)	**-**
Total	1,803	-	**1,803**

* See page 23

1.22 Going Concern

The Trustees have prepared the financial statements on a going concern basis, notwithstanding net current liabilities of £576,000 which they consider is appropriate for the following reasons. The business model of the charity is such that its charitable activities are limited to those which is has sufficient funds to support from the excess of funding received over the costs of administering the charity. The charity therefore has no specific commitments and no committed costs beyond its fixed costs of operation which are detailed in the notes.

The Trustees have reviewed cash flow forecasts for a period of 12 months from the date of approval of these financial statements which indicate that the charity will have sufficient funds to meet its liabilities as they fall due for that period. The net current liabilities arise due to the creditor balance payable to its parent, and its parent (and trustee) has indicated that it will not seek repayment of this debt until the charity has sufficient cash balances from the realisation of investments or donations received. The Trustees have also considered the implications of COVID-19 on those cash flow forecasts and consider that as a result of the charities operating model explained above, even if no further funding is received in the 12 months period, the charity has sufficient cash reserves to pay all committed costs. As a result, the Trustees consider it appropriate for the financial statements to be prepared on a going concern basis.

1.23 Public Benefit Entity

This is an NHS Charity, a public benefit entity, whose purposes are detailed in the introduction on page 3.

Charity Fund Applications are reviewed, and approval given (within the authorites detailed on page 26), with due regard to the commission's public benefit guidance and the purposes of the charity.

1.24 Judgements and Estimations

The accounts include commitments for items approved through the Charity Fund Approval process (see note 13). The values of these approvals will be based on best estimate of costs, some supported by quotations, purchase orders and costed internal recharges.

1.25 Donated Goods, Facilities or Services

The Charity received no material donated goods, facilites or services, (2018/19 estimated £10,000).

Events may be held on third party sites, but costs associated with events would be recorded under cost of generating funds expenditure.

1.26 Volunteers

Volunteers have played a role in the running of the Charity's events, as detailed on page 18.

1.27 Irrecoverable VAT

Irrecoverable VAT is charged aginst the category of resources expended for which it was incurred.

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1.28 Taxation Liability

As a registered charity, the fund is potentially exempt from the taxation of income and gains falling within S505 of the Income and Corporation Taxes Act 1988 and S256 Taxations and Chargeable Gains Act 1992.

No tax charge has arisen in the year.

1.29 Cash at bank and in hand

Cash at bank is the sum of all coins, currency and other unrestricted liquid funds that have been placed on deposit with a financial institution. Cash in hand is the amount of money held in notes and coins not on deposit.

2.1 Details of material incoming resources

	Unrestricted Funds	Restricted Funds	**Total Funds 2019-20**	Total Funds 2018-19
Material incoming resources:	£000	£000	**£000**	£000
Charities Office	-	167	**167**	413
RBCH General	331	-	**331**	341
Appeals Shop	30	-	**30**	28
Urology	30	-	**30**	5
March for Men	-	27	**27**	-
Twilight Fund	-	31	**31**	-
Walkerbot Appeal	-	172	**172**	-
Sustain	-	72	**72**	-
Coronary Care	95	-	**95**	1
RBH/XCH Heart	26	-	**26**	123
Stroke Unit	14	-	**14**	8
Cancer Care	130	-	**130**	165
Bournemouth Eye Unit	188	-	**188**	252
Others	72	1	**73**	434
Total incoming resources	916	470	**1,386**	1,770

2.2 Incoming resources received by category

	Total Funds 2019-20	Total Funds 2018-19
Description of the sources of any incoming resources by category:	**£000**	£000
Donations	**247**	228
Legacies	**485**	537
Activity Income from Fundraising Events	**440**	760
Other Grants Receivable	**207**	231
Interest / Dividends	**6**	4
Other Income	**1**	-
Notional Income for gifts in kind	**-**	10
Total	**1,386**	1,770

2.3 Income from Third Parties for recharged expenditure

	Total Funds 2019-20	Total Funds 2018-19
Details of material Third Party recharges during the year, including Donations:	**£000**	£000
Bournemouth Hospital League of Friends	**-**	97
Christchurch Hospital League Of Friends	**-**	2
Friends of Victoria Hospital Winborne	**28**	181
Bournemouth Healthcare Trust	**-**	24
Bournemouth Leukaemia Fund	**43**	-
Pears Foundation	**36**	-
Other	**5**	8
Total	**112**	312

Bournemouth Hospital Charity Annual Report and Accounts

3.1 Costs of Raising Funds

	Total 2019-20	Total Funds 2018-19
	£000	£000
Fundraising recharge (including staff recharge costs)	**306**	350
Publicity costs *	**78**	30
Total fundraising costs	**384**	380
Total funds raised from events held during the year **	**440**	760

Note:

* Publicity costs are included within Total Fundraising costs within the financial statements.
** The total funds raised excludes donations received directly into the Charity Office, which are included within Donations.

Further breakdown of the activities undertaken by the Fundraising Department during the year can be found in the Annual Report 2019-20.

3.2 Other Expenditure

	Unrestricted Funds	Restricted Funds	**Total Funds 2019-20**	Total Funds 2018-19
	£000	£000	**£000**	£000
Patient welfare and amenities	417	18	**435**	340
Staff welfare and amenities	368	6	**374**	204
Contributions to NHS	919	88	**1,007**	757
Miscellaneous	(58)	77	**19**	89
Notional expenditure for gifts in kind	-	-	**-**	10
End of Year commitments	(1,156)	28	**(1,128)**	450
Total	490	217	**707**	1,850

Governance costs have been apportioned to unrestricted funds as shown in note 1.20. Further breakdown of the resources expended during the year can be found in the Annual Report 2019-20.

The figure for commitments represents the movement in year, rather than the amount of new commitments made - a negative figure indicates that the commitments outside at the end of the year were lower than at the start.

3.3 Grants made to Institutions

	Aggregate amount paid 2019-20	Aggregate amount paid 2018-19
Grants paid to Royal Bournemouth and Christchurch Hospital NHS Foundation Trust*:	**£000**	£000
Property, Plant and Equipment, recorded in the Trust accounts	**892**	750
Expenditure to the Trust, recorded in the Trust accounts	**0**	0
Expenditure for staff and patient benefit, not recorded in the Trust accounts	**(185)**	1,100
Total	**707**	1,850

Details of grants paid to institutions during the year can be found in a summary of Charitable Fund Balances, which is available on request from the Trust.

4.1 Analysis of Governance Costs

	Unrestricted Funds	Restricted Funds	**Total Funds 2019-20**	Total Funds 2018-19
	£000	£000	**£000**	£000
External Audit fee (including VAT)	5	-	**5**	5
Miscellaneous	56	-	**56**	50
Total	61	0	**61**	55

Governance cost have been apportioned across expenditure types as shown in note 1.20.

4.2 Support Costs

There are no support costs, other than the Governance costs reported in note 4.1. These costs have been apportioned to the funds as detailed in note 1.20.

4.3 Auditor Remuneration

	Total 2019-20	Total 2018-19
	£000	£000
Statutory audit fee	**5**	5
Total	**5**	5

5 Analysis of Total Resources Expended

	Cost of Generating Funds	Cost of Activities for Charitable Objectives	Governance Costs	**Total 2019-20**	Total 2018-19
	£000	£000	£000	**£000**	£000
External Audit fee- statutory audit	-	-	5	**5**	5
Indemnity insurance	-	-	1	**1**	1
Bought-in services from NHS	-	-	55	**55**	49
Other	384	646	-	**1,030**	2,175
Total	384	646	61	**1,091**	2,230

6 Changes in Resources Available for Charity

	Unrestricted Funds	Restricted Funds	**Total Funds 2019-20**	Total Funds 2018-19
	£000	£000	**£000**	£000
Net movement in funds for the year	(191)	248	**57**	(316)
Net movement in funds available for future activities	(191)	248	**57**	(316)

* See page 23

Bournemouth Hospital Charity Annual Report and Accounts

7.1 Tangible Fixed Assets

The charity has no tangible fixed assets.

7.2 Intangible Fixed Assets

The charity has no intangible fixed assets.

7.3 Heritage Assets

The charity has no heritage assets.

8.1 Analysis of Fixed Asset Investments

	2019-20	2018-19
Fixed Asset Investments:	**£000**	£000
Market value at 31 March	**4,209**	4,065
Net gain / (Loss) on revaluation	**(219)**	144
Market value at 31 March	**3,990**	4,209
Historic cost	**2,850**	2,850

8.2 Market value at 31 March:

	Held in UK	**2019-20 Total**	2018-19 Total
	£000	**£000**	£000
Investments in a Common Deposit Fund or Common Investment Fund	3,990	**3,990**	4,209

Bournemouth Hospital Charity Annual Report and Accounts

8.3 Analysis of Narrow Range Investments

	UK Holdings	Non-UK	**2019-20 Total**	2018-19 Total
(Fixed) Short-term Deposits:	£000	£000	**£000**	£000
Market value at 31 March 2019	57	9	**66**	66
Net gain / (Loss) on revaluation	(17)	(2)	**(19)**	-
	40	7	**47**	66

8.4 Analysis of Gross Income from Investments

	Total 2019-20	Total 2018-19
	£000	£000
Total gross income	**6**	4
Other investments	**6**	4

Included in this total is income from non-UK Stocks and Equities amounting to less than £1k.

9 Debtors

Debtors are recognised when a legal or constructive obligation to pay is created, the amount can be measured reliably and it is probable that payment will be received.

	2019-20	2018-19
Amounts falling due within one year as at 31 March:	**£000**	£000
Other debtors	**75**	101
Total Debtors	**75**	101

10 Analysis of Creditors

	2019-20	2018-19
Amounts falling due within one year as at 31 March:	**£000**	£000
Other creditors	**463**	86
Accruals (see note 13.1)	**913**	1,896
Total creditors falling due within one year	**1,376**	1,982

11.1 Analysis of Funds

	Restated Balance 31 March 2019	Incoming Resources	Resources Expended	In Year Commitment	Gains and Losses	**Balance 31 March 2020**
Unrestricted:	£000	£000	£000	£000	£000	**£000**
Medical Equipment	60	-	(87)	21	13	**7**
RBCH General	160	331	(530)	273	(35)	**199**
Appeals Shop	24	30	(23)	6	(12)	**25**
Colorectal Fund	30	5	(18)	5	(6)	**16**
ITU/CCU Patients	13	8	(9)	(5)	(1)	**6**
Urology	7	29	(19)	13	(14)	**16**
Gynaecological Care	14	3	(12)	4	(3)	**6**
Breast Care	45	6	(26)	6	(7)	**24**
Chest Diseases	27	1	(15)	15	(9)	**19**
RBH/XCH Heart	79	26	(186)	135	(16)	**38**
Diabetes	28	1	(14)	2	(4)	**13**
Stroke Unit	40	14	(45)	4	(4)	**9**
Rehabilitation	12	1	(10)	(1)	1	**3**
Coronary Care Unit	14	95	(12)	7	(41)	**63**
Cancer Care	160	130	(240)	142	(65)	**127**
Breast Oncology	57	1	(27)	-	(5)	**26**
Bournemouth Eye Unit	38	188	(266)	72	(10)	**22**
Others	63	47	(341)	312	(20)	**61**
Total Unrestricted	871	916	(1,880)	1,011	(238)	**680**
Restricted:						
Orchard Garden	8	-	(1)	1	-	**8**
Jigsaw - New Build	1,651	-	-	-	-	**1,651**
March for Men	13	27	(34)	39	-	**45**
Twlight Fund	25	31	(18)	3	-	**41**
Christchurch Refurb	296	1	-	1	-	**298**
Charity Office	493	167	(141)	(64)	-	**455**
Sustain	-	72	-	-	-	**72**
Walkerbot Appeal	-	172	-	(8)	-	**164**
Total Restricted	2,486	470	(194)	(28)	-	**2,734**
Total of all Funds	3,357	1,386	(2,074)	983	(238)	**3,414**

The restricted funds March for Men, Twilight Fund, and Christchurch refurbishment were reported under the Unrestricted category in 2018/19. These have now been correctly categorised and the opening balance restated.

Bournemouth Hospital Charity Annual Report and Accounts

11.2 Details of Material Funds

Medical Equipment	For purchases and/or maintenance of medical equipment within the Trust
RBCH General	General purposes of the Royal Bournemouth &Christchurch Hospitals
Appeals Shop	Any purpose relating to the shop run by the charity at Royal Bournemouth Hospital
Colorectal Fund	Any purpose relating to colorectal surgery within the Trust
ITU/CCU Patients	For the benefit of patients in the Intensive Therapy Unit or Critical Care Unit of the Trust
Urology	Any purpose relating to the Urology Department of the Trust
Gynaecological Care	Any purpose relating to gynaecological care within the Trust
Breast Care	Any purpose relating to the provision of breast care within the Trust
Chest Diseases	Any purpose relating to the treatment of chest diseases within the Trust
RBH/XCH Heart	Any purpose relating to the treatment of heart conditions within the Trust
Diabetes	Any purpose relating to the treatment of diabetes within the Trust
Stroke Unit	Any purpose relating to stroke rehabilitation within the Trust
Rehabilitation	Any purpose relating to rehabilitation within the Trust
Coronary Care Unit	Any purpose relating to coronary care within the Trust
Cancer Care	Any purpose relating to the treatment of cancer within the Trust
Breast Oncology	Any purpose relating to the treatment of breast cancer within the Trust
Bournemouth Eye Unit	Any purpose relating to the Eye Unit of the Trust
Orchard Garden	Any purpose relating to the establishment and maintenance of the Orchard Garden
Jigsaw - New Build	Funds held for the Jigsaw Building
March for Men	Any purpose relating to the fundraising for the March for Men cause
Twilight Fund	Any purpose relating to the fundraising for the Twilight cause
Christchurch Refurbishment	Any purpose relating to the refurbishment of Christchurch Hospital
Charity Office	Any charitable funds held with specific one-off restrictions
Sustain	Any purpose relating to the Stroke Unit within the Trust
Walkerbot Appeal	Any purpose relating to the fundraising for the Walkerbot cause
Others	This represents all other unrestricted funds under the classification of "Umbrella funds"

12 Contingencies

The following contingent gains have not been included in the accounts:

	2019-20	2018-19
Contingent gains:	**£000**	£000
Outstanding Legacies	**478**	156
Total contingent gains	**478**	156

13 Commitments, Liabilities and Provisions

13. 1 Commitment Breakdown for 2019/20

	Capital	Other	**Total**
	£000	£000	**£000**
Brought Forward Commitments as at 31 March 2019	991	905	**1,896**
Prior Commitments spent during 19/20	**(868)**	**(540)**	**(1,408)**
Remaining prior commitment	123	365	**488**
New commitments during 19/20	133	292	**425**
Commitments as at 31 March 2020	256	657	**913**

Large Commitments 19/20 - Projected expenditure dates	CFA	Value	Estimated
	Number	£000	Expend Date
50% of costs to reconfigure the Eye Emergency Department & Eye Outpatients Department	RBH2210	206	2020-21
Refurbishment of Patient bathrooms on Ward 11	RBH1785	89	2020-21
Cirrus 5000 Angioplex & Cirrus photo	RBH2347	87	2020-21
2 x staff members to be funded to develop youth volunteer service	RBH2420	76	2020-21
Salary for Oncology advanced nurse practitioner to be based on the Haematology and Oncology Unit	RBH1730	52	2020-21
Upgrade & increase the trusts provision of flat lifting equipment	RBH2421	33	2020-21
Zeiss IOL Master Machine	RBH2395	32	2020-21
Upgrade to the Orchard Garden project	RBH1573	32	2020-21
Call down for annual social fund 2019	RBH2383	28	2020-21
2 x band 4 cancer support workers M07-M12 19/20	RBH2399	21	2020-21
Purchase of new DXA Machine	RBH1615	18	2020-21
To purchase an Aircool 12 in order to increase mortuary capacity	RBH1153	15	2020-21

Bournemouth Hospital Charity Annual Report and Accounts

13.2 Liabilities

The Trustee recognise liabilities in the accounts once they have incurred either a legal or constructive obligation to expend funds.

Commitments totalling £913,154.59 relating to grants payable, have been included in the accounts.

14 Indemnity Insurance

	2019-20	2018-19
Description of Cover:	**£000**	£000
Trustee Indemnity Insurance	**1**	1

15 Connected Organisations

	2019-20		2018-19	
	Operating Income	Audited Surplus/ (Deficit)	Operating Income	Audited Surplus/ (Deficit)
Name of Organisation	**£000**	**£000**	£000	£000
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*	**337,495**	**27,234**	336,380	27,859

* See page 23

Thank you

to the volunteers, supporters, fundraisers and groups without whom we would not be able to provide the many benefits to the patients and staff at the Royal Bournemouth and Christchurch Hospitals. We simply cannot thank everyone so here are a few of our major donors and supporters:

Gerry and Pauline Smith
Alan Miller Estate
Sustain
Bournemouth Leukaemia Fund
Pears #iWill Fund
Friends of the Bournemouth Eye Unit
Going for Bust
Valerie Besson Will Trust
Charles Skey Charitable Trust
The Friendly Fundraisers
Superior Group Ltd
JL Dalton Charitable Trust
Byron Road Christmas Lights
Pink Ribbon Foundation
Chewton Glen Health Club
Talbot Rise Club
Volatile Agents
Bournemouth Male Voice Choir
Symonds & Sampson
Christchurch Drill Hall Charity Trust
Bournemouth Joggers

KPMG

External Audit Report

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund

Year ended 31 March 2020

30 October 2020

Contents

This report is made solely to the Trustee of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund ('the Charity'), in accordance with the terms of our engagement. It has been released to the Trustee on the basis that this report shall not be copied, referred to or disclosed, in whole (save for the Trustee's own internal purposes) or in part, without our prior written consent. Matters coming to our attention during our audit work have been considered so that we might state to the Trustee those matters we are required to state to the Trustee in this 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 Charity and its Trustee, for our work referable to this report, for this report, or for the opinions we have formed.

Please note that that this report is confidential between the Trustee and this firm. Any disclosure of this report beyond what is permitted above will prejudice this firm's commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If the Trustee receives a request for disclosure of this report under the Freedom of Information Act 2000, having regard to these actionable disclosure restrictions you must let us know and you must not make a disclosure in response to any such request without our prior written consent.

Executive summary

The purpose of this memorandum is to set out the significant issues that came to our attention during the course of the audit of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Funds for the year ended 31 March 2020.

Our objective is to use our knowledge of the Charity, gained during our routine audit work, to make useful comments and suggestions for you to consider. However, you will appreciate that our routine audit work is designed to enable us to form opinions on the Charity's financial statements and it should not be relied upon to disclose all irregularities that may exist, nor to disclose errors that are not material to the financial statements and contributions.

Audit conclusions	
✓	— We propose an unqualified audit opinion on the financial statements.
Accounting matters	
✓	— No significant accounting issues arose during the course of our audit.
✓	— The charity adopted appropriate accounting policies and the financial statements are in accordance with the disclosure requirements of relevant charities legislation, UK GAAP and the Statement of Recommended Practice. — On 1 October 2020, RBCH NHS FT and Poole NHS FT merged into a newly formed Trust, University Hospital Dorset. We have reviewed the required disclosures to explain this change in trustee within the accounts.
Auditing matters	
✓	— At the time of drafting this report our work is substantially complete however the following work is still in the process of being completed: – Final review of the Trustee's Report and the accounts.
✓	— No significant audit issues arose during the course of our audit of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Funds.
Systems and controls	
✓	— We have not identified any issues in relation to the systems and controls in place at the Charity.
Regulatory and tax matters	
✓	— No significant regulatory or tax matters came to our attention during the course of our normal audit work.

KPMG

Appendices

1. Mandatory communications
2. Audit Independence

Appendix 1

Mandatory communications

We set out below details of the required communications to the Trustee.

Adjusted audit differences Adjustments made as a result of our audit	Under the requirements of Clarified ISA 260 *Communication of audit matters with those charged with governance*, we are required to report any adjusted audit misstatements arising from our work. We are pleased to report that there were no adjusted audit differences.
Unadjusted audit differences Audit differences identified that we do not consider material to our audit opinion	There were no unadjusted audit differences.
Management representation letter Letter issued by the Charity to KPMG prior to audit sign-off	In accordance with ISA 580 Written representations, we request written representations from those charged with governance. Written representations are necessary information we require in connection with the audit of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Funds. The draft written representations have been provided to the Trustee.
Related parties	There were no significant matters that arose during the audit in connection with the entity's related parties.
Other matters to report to those charged with governance	There are no other matters that we wish to report to those charged with governance.
Difficulties encountered in performing the audit	There have been no disagreements with management on financial accounting and reporting matters that, if not satisfactorily resolved, would have caused a modification of our auditors' report on the Charity's financial statements. We encountered no fundamental difficulties in dealing with management in performing the audit.

Appendix 2
Audit independence

We confirm that, in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and that the objectivity of the Partner and audit staff is not impaired.

To the Audit Committee members

Assessment of our objectivity and independence as auditor of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust ('the Trust')

Professional ethical standards require us to provide to you at the conclusion of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical Standard. As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

We are satisfied that our general procedures support our independence and objectivity

Independence and objectivity considerations relating to the provision of non-audit services

Summary of fees

We have considered the fees charged by us to the Trust and its affiliates for professional services provided by us during the reporting period. We have detailed the fees charged by us to the company and its related entities for significant professional services provided by us during the reporting period below, as well as the amounts of any future services which have been contracted or where a written proposal has been submitted. Total fees charged by us for the period ended 31 March 2020 can be analysed as follows:

Component of audit (all fees exclude VAT)	
	2019/20
Audit services – statutory audit	
Financial Statements Audit	£4,000
Fee for Charity	**£4,000**

We have not provided any non-audit services during 2019/20.

Appendix 2

Audit independence

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgment, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the Audit Committee of the Trust and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

Yours faithfully

KPMG LLP

KPMG

kpmg.com/socialmedia

kpmg.com/app

[Letterhead of Client]

KPMG LLP
66 Queen Square
Bristol
BS1 4BE

[Date]

Dear Jon

This representation letter is provided in connection with your audit of the financial statements of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund ("the Charity"), for the year ended 31 March 2020, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the state of the Charity's affairs as at 31 March 2020 and of its surplus or deficit for the financial year then ended;
ii. whether the financial statements have been properly prepared in accordance with UK Generally Accepted Accounting Practice (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and
iii. whether the financial statements have been prepared in accordance with the Charities Act 2011.

These financial statements comprise the Balance Sheet, the Statement of Financial Activities and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Trustees confirm that the Charity is exempt from the requirement to also prepare consolidated financial statements.

The Trustees confirm that the representations they make in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Trustees confirm that, to the best of their knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing themselves:

Financial statements

1. The Trustees have fulfilled their responsibilities for the preparation of financial statements that:

    i. give a true and fair view of the state of the Charity's affairs as at the end of its financial year and of its surplus or deficit for that financial year;
    ii. have been properly prepared in accordance with UK Generally Accepted Accounting Practice ("UK GAAP") (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and
    iii. have been prepared in accordance with the Charities Act 2011.

The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Trustees in making accounting estimates, including those measured at fair value, are reasonable.

3. All events subsequent to the date of the financial statements and for which section 32 of FRS 102 requires adjustment or disclosure have been adjusted or disclosed.

Information provided

4. The Trustees have provided you with:

    - access to all information of which they are aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
    - additional information that you have requested from the Trustees for the purpose of the audit; and
    - unrestricted access to persons within the Charity from whom you determined it necessary to obtain audit evidence.

5. All transactions have been recorded in the accounting records and are reflected in the financial statements.

6. The Trustees confirm the following:

    i) The Trustees have disclosed to you the results of their assessment of the risk that the financial statements may be materially misstated as a result of fraud.

    Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

    ii) The Trustees have disclosed to you all information in relation to:

    a) Fraud or suspected fraud that it is aware of and that affects the Charity and involves:
        - management;
        - employees who have significant roles in internal control; or
        - others where the fraud could have a material effect on the financial statements; and

    b) allegations of fraud, or suspected fraud, affecting the Charity's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Trustees acknowledge their responsibility for such internal control as they determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Trustees acknowledge their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

7. The Trustees have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

8. The Trustees have disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with section 21 of FRS 102 all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

9. The Trustees have disclosed to you the identity of the Charity's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with section 33 of FRS 102.

10. The Trustees confirm that:

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the charity's ability to continue as a going concern as required to provide a true and fair view.
    b) No events or circumstances have been identified that may cast significant doubt on the ability of the Charity to continue as a going concern.

Yours sincerely,

[Chair of Trustees]

[Trustee]

Appendix to the Trustees' Representation Letter of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund: Definitions

Financial Statements

A complete set of financial statements comprises:

- a Balance Sheet as at the end of the period;
- a Statement of Financial Activities for the period; and
- notes, comprising a summary of significant accounting policies and other explanatory information.

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

FRS 102 states that:

Omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or combination of both, could be the determining factor.

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and
b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

Qualifying Entity

A member of a group where the parent of that group prepares publicly available consolidated financial statements which are intended to give a true and fair view (of the assets, liabilities, financial position and profit or loss) and that member is included in the consolidation by means of full consolidation.

Related Party and Related Party Transaction

Related party:

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in FRS 102 as the "reporting entity").

a) A person or a close member of that person's family is related to a reporting entity if that person:
    i. has control or joint control over the reporting entity;
    ii. has significant influence over the reporting entity; or
    iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
b) An entity is related to a reporting entity if any of the following conditions apply:
    i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
    ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
    iii. Both entities are joint ventures of the same third party.
    iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
    v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
    vi. The entity is controlled, or jointly controlled by a person identified in (a).
    vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).
    viii. The entity, or any member of a group of which is is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity.

Related party transaction:

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

GLOSSARY OF ABBREVIATIONS

A

A&E	*Accident and Emergency*
A&G	*Audit and Governance Committee*
ACT	*Alcohol Care Team*
ADHD	*Attention deficit hyperactivity disorder*
AF	*Atrial fibrillation*
AfC	*Agenda for Change*
AHPs	*Allied Health Professionals*
AHSN	*Academic Health Science Network*
AI	*Artificial intelligence*
AIRS	*Adverse Incident Reporting System*
ALB	*Arm's Length Body*
AMM	*Annual Members' Meeting*
API	*Application programming interface*
AQP	*Any Qualified Provider*
ASI	*Appointment Slot Issues*

B

BAF	*Board Assurance Framework*
BAME	*Black, Asian and Minority Ethnic*
BCF	*Better Care Fund*
BMA	*British Medical Association*
BMI	*Body mass index*
BoD	*Board of Directors*

C

CAS	*Clinical Assessment Service*
CAU	*Clinical Assessment Unit*
C.Diff	*Clostridium difficile*
CCG	*Clinical Commissioning Group*
CCIO	*Chief Clinical Information Officer*
CCU	*Coronary Care Unit*
CE	*Chief Executive*
CEA	*Clinical Excellence Awards*
CEPOD	*Confidential Enquiry into Perioperative Death*
CETR	*Care, Education and Treatment Review*
CGG	*Clinical Governance Group*
CHKS	*A national independent provider of comparative performance and healthcare data*
CI	*Confidence interval*
CIO	*Chief Information Officer*
CIP	*Cost Improvement Plan*
CMA	*Competition and Markets Authority*
CNST	*Clinical Negligence Scheme for Trusts*
COAST	*Children's Observations and Severity Tool*
CoG	*Council of Governors*
COO	*Chief Operating Officer*
COPD	*Chronic obstructive pulmonary disease*
CoSRR	*Continuity of Service Risk Rating*
CP	*Chief Pharmacist*
CPD	*Continuing professional development*

CPR	*Cardiopulmonary resuscitation*
CQC	*Care Quality Commission*
CQUIN	*Commissioning for Quality and Innovation*
CRES	*Cost Releasing Efficiency Saving*
CRN	*Clinical Research Network*
CRT	*Clinical Record Tracking*
CSR	*Clinical Services Review*
CSTR	*Community Service Treatment Requirement*
CT	*Computerised Tomography*
CTR	*Care and Treatment Review*
CVD	*Cardiovascular disease*

D

Datix	*National Software Programme for Risk Management*
DBS	*Disclosure and Barring Service*
DHSC	*Department of Health and Social Care*
DNA	*Did not attend*
DoF	*Director of Finance*
DoH	*Department of Health*
DoN	*Director of Nursing*
DDoN	*Deputy Director of Nursing*
DoW&OD	*Director of Workforce and Organisational Development*
DoS	*Director of Strategy*
Dr Foster	*Provides health information and NHS performance data to the public*
DToC	*Delayed Transfer of Care*

E

EBITDA	*Earnings Before Interest, Taxation, Depreciation and Amortisation*
EBME	*Electrical, Biomedical Equipment*
ECDS	*Emergency Care Data Set*
EEA	*European Economic Area*
EHCH	*Enhanced Health in Care Homes*
eNEWS	*National Early Warning Score*
ENT	*Ear, Nose and Throat*
EPR	*Electronic patient record*
EPRR	*Emergency Planning Resilience & Reponse*
EPS	*Electronic Prescription Service*
ERCP	*Endoscopic Retrograde Cholangiopancreatography*
ESBL	*Extended Spectrum Beta Lactamase (producer) Klebsiella*
ESCAPE-pain	*Enabling Self-management and Coping with Arthritic Pain through Exercise*
ESR	*Electronic Staff Record*
EWTD	*European Working Time Directive*

F

FCE	*Finished Consultant Episode*
FCP	*First Contact Practitioner*
FFCE	*First Finished Consultant Episode*
FFT	*Friends and Family Test*
FH	*Familial Hypercholesterolemia*
FIC	*Finance and Investment Committee*
FOI	*Freedom of Information*
FRP	*Financial Recovery Fund*

FT	*NHS Foundation Trusts*
FTE	*Full-time equivalent*
FPPRG	*Future Plans and Priorities Reference Group.*
FRP	*Financial Recovery Plan.*

G

GBD	*Global Burden of Disease*
GDE	*Global Digital Exemplar*
GDP	*Gross domestic product*
GIRFT	*Getting It Right First Time*
GMC	*General Medical Council*
GP	*General practitioner*
GTDRG	*Governor Training & Development Reference Group*
GVA	*Gross Value Added*

H

H@N	*Hospital at Night*
HDU	*High Dependency Unit*
HEE	*Health Education England*
HEI	*Higher Education Institution*
HFMA	*Healthcare Financial Management Association*
HFSS	*High in fat, salt and sugar*
HoC	*Head of Communications*
HPV	*Human papilloma virus*
HR	*Human Resources*
HRG	*Healthcare Resource Group*
HSE	*Health & Safety Executive*
HSMR	*Hospital Standardised Mortality Ratios*

I

I&E	*Income and Expenditure*
IAPT	*Improving Access to Psychological Therapies*
ICP	*Integrated Care Provider*
ICS	*Integrated Care System*
ICU or ITU	*Intensive Care Unit or Intensive Therapy Unit*
IG	*Information Governance*
IPG	*Investment Planning Group*
IPR	*Integrated Performance Report*
IPS	*Individual Placement and Support*
ISDN	*Integrated Stroke Delivery Network*
IT or IM&T	*Information Technology or Information Management & Technology*

K

KPI	*Key Performance Indicator*
KSF	*Knowledge & Skills Framework*

L

LCFS	*Local Counter Fraud Specialist*

LeDeR *Learning Disabilities Mortality Review Programme*
LGBT+ *Lesbian, Gay, Bisexual, Transgender*
LHCR *Local Health and Care*
LHRP *Local Health Resilience Partnership*
LiNAC *Linear Accelerator*
LNC *Local Negotiating Committee*
LocSSIPs *Local Safety Standards for Invasive Procedures*
LoC *Letter of Claim*
LoS *Length of Stay*
LTFM *Long Term Financial Model*
LTP *Long Term Plan*

M

MARS *Mutually Agreed Resignation Scheme*
MCP *Multispecialty community provider*
MD *Medical Director*
MDT *Multi-Disciplinary Team*
MERG *Membership Engagement and Recruitment Group*
Mortality rate *The ratio of total deaths to total population in relation to area and time.*
MRI *Magnetic Resonance Imaging*
MRSA *Methicillin Resistant Staphylococcus Aureus*
MSC *Medical Staffing Committee*
MSK *Musculoskeletal*

N

NatSSIPs *National Safety Standards for Invasive Procedures*
NCEPOD *NCEPOD (National Confidential Enquiry into Perioperative Death)*
NED *Non-Executive Director*
NEWS2 *National Early Warning Score 2*
NHS *National Health Service*
NHSI *NHS Improvement - The independent regulator of NHS Foundation Trusts*
NHSIQ *NHS Improvement Quality*
NHSLA *National Health Service Litigation Authority*
NICE *National Institute for Health & Clinical Excellence*
NICU *Neonatal Intensive Care Unit*
NIHR *National Institute for Health Research*
NMC *Nursing and Midwifery Council*
NMG *Nursing and Midwifery Group*
NOF *Neck of Femur*
NPfIT *National Programme for Information Technology*
NPSA *National Patient Safety Agency*
NREC *Nominations, Remuneration & Evaluations Committee*
NRLS *National Reporting and Learning System*
NSF *National Service Framework*
NVQ *National Vocational Qualification*

O

OD *Organisational Development*
OECD *Organisation for Economic Co-operation and Development*
OFRG *Operational Finance Reference Group*
OFT *Office of Fair Trading*
OMF *Oral Maxillo Facial*

P

PA/SPA	*Programmed Activities and Supporting Professional Activities*
PACS	*Picture Archiving and Communications System – the digital storage of x-rays or Primary Acute Care Systems*
PALS	*Patient Advice and Liaison Service*
PBC	*Practice Based Commissioning*
PbR	*Payment by Results*
PEAT	*Patient Environment Action Team*
PET	*Position emission tomography scanning system*
PEWS	*Poole Early Warning System*
PFI	*Private Finance Initiative*
PHB	*Personal health budget*
PHE	*Public Health England*
PHFT	*Poole Hospital NHS Foundation Trust*
PHR	*Personal health record*
PID	*Project Initiation Document*
PLICS	*Patient Level information and costing systems – data collection system*
PMO	*Project Management Office*
PROM	*Patient Recorded Outcomes Measures*
PST	*Patient Safety Thermometer*
PTIP	*Post Transaction Implementation Plan*
PYLL	*Potential Years of Life Lost*

Q

QI	*Quality Improvement*
QIA	*Quality Impact Assessment*
QIPP	*The Quality, Innovation, Productivity and Prevention Programme*
QNI	*Queen's Nursing Institute*
QOF	*Quality and Outcomes Framework*
QPR	*Quarterly Performance Review*
QSPC	*Quality, Safety & Performance Committee*

R

R&D	*Research and development*
RACE	*Rapid Assessment and Consultant Evaluation for older people*
RBH	*Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust*
RCI	*Reference Cost Index*
RDC	*Rapid Diagnostic Centre*
RTT	*Referral to Treatment. The current RTT Target is 18 weeks.*

S

SaaS	*Software as a Service*
SALT	*Speech and Language Therapy*
SAU	*Surgical Assessment Unit*
SBLCB	*Saving Babies Lives Care Bundle*
SCCL	*Supply Chain Coordination Limited*
SDEC	*Same Day Emergency Care*
SHMI	*Summary Hospital Mortality Indicator*
SFIs	*Standing Financial Instructions*

SI	*Serious Incident*
SID	*Senior Independent Director*
SIRO	*Senior Information Risk Owner*
SLA	*Service Level Agreement*
SLM	*Service Line Management*
SLR	*Service Line Report*
SMR	*Standardised Mortality rate – see Mortality Rate*
SPF	*Staff partnership Forum*
SpR	*Specialist Registrar – medical staff grade below consultant*
SSNAP	*Sentinel Stroke National Audit Programme*
STEIS	*Strategic Executive Information System*
STAMP	*Supporting Treatment and Appropriate Medication in Paediatrics*
STOMP	*Stopping over medication of people with a learning disability autism or both*
STP	*Sustainability and Transformation Plan*
SUS	*Secondary Uses Service*

T

TAL	*NHS Direct provides The Appointments Line service as part of Choose & Book*
TIAA	*The trust's internal auditors*
TOR	*Terms of Reference*

U

UCLH	*University College London Hospitals*
UNICEF	*United National International Children's Emergency Fund*
UTC	*Urgent Treatment Centre*

V

VCSE	*Voluntary, Community and Social Enterprise*
VFC	*Virtual Fracture Clinic*
VfM	*Value for Money*
VIP Score	*Visual Infusion Phlebitis of intravenous cannuloe – scoring system*
VSM	*Vey Senior Manager*
VTE	*Venous Throboembolism*

W

WODC	*Workforce and Organisational Development Committee*
WTE	*Whole Time Equivalent*

Y

YTD	*Year to Date*

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