The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust


# Annual Report and Accounts 2020/21

## (part-year) 1 April to 30 September 2020





# The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

## Annual Report and Accounts 2020/21 (part-year)

1 April to 30 September 2020

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

# Contents

# Foreword

**From our Joint Chief Executive and Chairman**

Welcome to the final annual report for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH). This report covers the last six months of our Trust from 1 April 2020 leading up to our merger with Poole Hospital NHS Foundation Trust (PHT) on 1 October 2020 to form University Hospitals Dorset NHS Foundation Trust (UHD). We shall be publishing our future annual reports as UHD, with the first one covering the six months from 1 October 2020 to 31 March 2021.

The first six months of 2020/21 were of course hugely overshadowed by the global Covid-19 pandemic, as has been the remainder of the year. Fortunately, our two trusts were already working together very closely, and this helped us enormously as we faced up to the Covid-19 challenge. We always knew that we would be stronger working together, and this has certainly been proved throughout the pandemic. Our Shadow Interim Board, approved back in December 2019, maintained an oversight of our combined response, making sure that all teams and all three sites worked effectively together (and with partners) to maintain essential services for the local population.

We would like to take this opportunity to thank all staff across both Trusts for their hard work and commitment during these unprecedented times. Staff were working under very difficult circumstances, yet each day, we saw incredible examples of courage, dedication and compassion, as teams worked together to ensure that the needs of their patients are met. It was a privilege to be leading two such impressive organisations, working with such incredible people. We are incredibly proud of the response of all our teams in stepping up this this challenge.

In response to the Covid-19 pandemic, we had to reconfigure services on all three of our sites, and radically change the way in which we delivered our services. This included segregating our Emergency Departments and Intensive Care facilities and creating a significant number of additional ICU beds in some of our operating theatres and other ward areas. This was a huge team effort, involving significant change and an enormous amount of work for our clinical and non-clinical staff alike, across all our sites. We cannot thank our staff enough for all that they have done over the past few months, in stepping up to this challenge and maintaining safe services for our patients. Every single member of staff deserves to be applauded for their efforts.

Working very closely in response to national guidance, our initial priorities when the first wave of the pandemic struck were as follows:

- to free-up the maximum possible inpatient and critical care capacity;
- to prepare for and respond to, the anticipated large numbers of Covid-19 patients likely to need respiratory support;
- to support staff, and maximise their availability

To free up capacity, we postponed all non-urgent elective operations, re-utilised the freed-up space and staff, and in doing so, were able to significantly increase our critical care capacity. We also freed up a large number of general medical beds through our collaborative efforts with our Community and Local Authority partners in order to discharge significant numbers of medically fit patients. Over the course of the period, the number of these patients has fluctuated, and at times, is still much higher than we would like. However, with the support of our partners, we have broadly been able to maintain patient flow through the hospital throughout the pandemic – and without this, we would not have been able to continue admitting acutely ill patients.

As the year has progressed, we have continued to prioritise high-risk and high-priority treatments, including accessing additional activity within the private sector made available as part of a wider national contract. We are very grateful to our local independent sectors partners – in particular, Nuffield Health Bournemouth Hospital and BMI The Harbour Hospital - who have worked very closely with our teams to prioritise urgent treatments.

On 2 June 2020, Public Health England published their review into disparities around coronavirus risk and this highlighted that across the UK, Black, Asian and minority ethnic (BAME) people are twice as likely to die of Covid-19 than white British people. This stark finding has redoubled our focus and that of our partners on tackling health inequalities, as emphasised in the NHS Long Term Plan. During the first six months of 2020/21, several members

of staff from across our two Trusts from a BAME background received treatment for Covid-19. Fortunately, all made a positive recovery.

The issue of racial discrimination and inequalities was again brought to the fore by the brutal death of George Floyd, resulting in a call for an end to racism, discrimination and injustice for black people across the world. Clearly, this has been an important issue for the NHS, both nationally and locally with the growth of the Black Lives Matter protests.

A joint statement on the matter was sent out to both Trusts from the Medical Director and the Chief Executive earlier in the year, outlining the commitment of both Trusts to ensuring that that our health service is a fairer and more compassionate place both in which to work and to receive care. A personal letter from the Chief Executive also went out to every BAME member of staff within our organisations, asking them to arrange a risk assessment and updating them on all the support that is available.

Clearly, as well as responding to the Covid-19 pandemic, a big focus for 2020/21 has been the progress made in taking forwards our merger. We were delighted in April with the news that the Competition and Markets Authority (CMA) had cleared the proposed merger between our two Trusts. The CMA's investigation in this case had confirmed that competition between NHS hospitals now played little role in the provision of NHS services in the east Dorset area, with collaboration often viewed as a better way of meeting increased demand for care and delivering better value. The CMA concluded that the merger did not give rise to competition concerns and therefore should be cleared. As such, the Trusts were released from the commitment that they had given in 2013 not to merge.

This announcement was very welcome news, as we have long been clear that our hospitals would be much stronger working together to provide care for our patients and local people. As well as being essential in order to take forward our plans to create a major emergency hospital and a major planned care hospital in east Dorset, the benefits of joint working have now been clearly demonstrated as we have worked through the Covid-19 pandemic.

As the year moved on, we were very proud when it was confirmed that our new organisation could have University Hospital status officially bestowed on us from 1 October. This meant that our new organisation would legally be known as University Hospitals Dorset NHS Foundation Trust (UHD). Our Board and other colleagues have since set in place arrangements to meet regularly with colleagues in Bournemouth University to establish robust governance arrangements and develop our joint five-year strategy. Achieving university hospital status emphasises UHD's commitment to teaching and research, which will significantly enhance our ability to recruit and retain staff. There is also evidence that University Hospitals deliver better outcomes for patients. Both RBCH and PHFT have a long history of collaborative working with Bournemouth University, which provides a very strong platform moving forwards.

As part of this year's planning guidance, great emphasis has again been placed on strengthening partnership and system working. In this way, partners are expected to better meet the needs of local people and use all resources to best effect.

Throughout the Covid-19 pandemic, partners within the Dorset system have been working very closely and effectively together, resulting in the development of even stronger relationships and more streamlined decision-making processes. This work will continue as we move into the "recovery stage".

It is anticipated that Integrated Care Systems (ICSs) will play an even more important role in the planning and delivery of integrated local services and in tackling health inequalities. As such our work in developing the Dorset ICS will continue to be a priority going forwards.

Throughout this time, we have been fortunate to have the support of our staff, governors, volunteers, fundraisers and members. Your hard work and dedication make our hospitals the places that they are today, and we should like to take this opportunity to sincerely thank you for your contribution. With your on-going support, our new Trust will be established as a listening and responsive organisation – one that continues to be valued and highly regarded within our local community.

Despite the disruption associated with COVID-19, we were delighted to go ahead with the Annual Members Meetings for each of our Trusts this autumn. Poole Hospital NHS Foundation Trust held its Annual Members Meeting on Thursday 17 September 2020, whilst The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust held its Annual Members meeting on Tuesday 29 September 2020. We were so pleased to be able to connect with our members and to share the challenges and successes of each Trust, whilst at the same time maintaining safety by broadcasting these events live via Microsoft Teams.

We are also grateful to all our partners across the Dorset Integrated Care System – that is, Dorset Healthcare, Dorset County Hospital, BCP Council, Dorset Council, South Western Ambulance Service, the Dorset Clinical Commissioning Group (CCG) Dorset Police and the Dorset Fire and Rescue Service for all their on-going support. We look forward to continuing to work closely with them as we further develop our Dorset ICS so that we might better meet the needs of local people.

In dealing with all the challenges associated with Covid-19, we have been really touched by the huge amount of support for the NHS that has been demonstrated by the general public. So many messages have been received, in so many ways, and these - coupled with the Thursday evening "Clap for Carers" - have really made our staff feel valued. All this support made such a difference at the start of the year in encouraging us to keep going on. We really appreciate the generosity of all those who have money, gifts and support to our Trusts. It means a lot to our staff to be recognised for their efforts, and to know that they are highly valued as they work to provide patients with the best possible care, during these difficult times.

We have a very exciting future ahead of us as the new University Hospitals Dorset NHS Foundation Trust, and we want it to be an even better place to work and to receive care than either of our predecessor Foundation Trusts. We know that we can serve local people better as a larger, more resilient organisation, and we are committed to delivering real benefits as a consequence of this change. Thank you for supporting us as we continue on our journey.

**David Moss,** Joint Chairman, 28 April 2021

**Debbie Fleming**, Joint Chief Executive, 28 April 2021

# About our Trust

Located about three miles apart on the south coast, the Royal Bournemouth and Christchurch hospitals are close to the New Forest in the east and the Jurassic coastline in the west. Also part of our organisation is a Sterile Services Department based at Alderney Hospital in Poole.

The hospitals became an NHS Foundation Trust on 1 April 2005. NHS Foundation Trusts are not-for-profit, public benefit corporations that were created to devolve decision-making from central government to local organisations and communities. We are still part of the NHS and strive to live up to its values, as set out in the Constitution. The Trust was issued with a provider licence by Monitor (now part of NHS Improvement) on 1 April 2013, which replaced the Trust's terms of authorisation.

We provide a wide range of hospital and community-based care to a population of 550,000 based in the Dorset, New Forest and south Wiltshire areas. This number rises over the summer months due to the influx of tourists which sees over 1 million visitors to our region annually. For some of our specialist services, we also serve the wider population across the whole of Dorset of nearly 1 million. Our business model is based on meeting commissioners' needs to secure most of our funding. The largest part of this is via Dorset CCG, within the ICS approach of a shared control total. We must manage our reference costs within the national tariff system to allow us to invest appropriately in the staff and wider infrastructure to provide safe and effective patient care.

We monitor our performance against a range of performance objectives and targets, some of which are set by us but others reflect national targets and those set by commissioners. Details of the performance on key performance, safety and quality objectives is set out in the performance analysis.

We provide a wide range of hospital and community-based care and at the end of September 2020 we employed 4,535 members of staff, both clinical and non-clinical.

Over the six months from 1 April 2020 to 30 September 2020 before we merged with Poole Hospital on 1 October 2020 we cared for and treated the following patients:

- Number of outpatient attendances (follow ups): 76,990
- Number of new outpatient attendances: 32,246
- Number of admissions 37,995:
- Number of attendances to Emergency Department Type 1 and 2: 40,632
- Number of attendances to Emergency Department – Urgent Treatment Centre: 1,478

**The Royal Bournemouth Hospital**
The Royal Bournemouth Hospital is an acute hospital, which opened in 1992. It is recognised locally by its blue roof and is located on a large green field site close to the main roads that link with the New Forest, Southampton, Salisbury, Winchester, Christchurch and Poole.

The hospital has a 24-hour Emergency Department which sees around 60,000 patients a year, and a large Day of Surgery Admissions Unit (the Sandbourne Suite). A purpose built Ophthalmic Unit is located on site as well as a state-of-the-art Cardiology Unit (the Dorset Heart Centre) and the award-winning orthopaedic service providing hip and knee replacements (the Derwent Unit). The Jigsaw Building is home to our HODU, a day unit for chemotherapy and supportive treatment for patients with haematological/oncological conditions and the Breast Unit. The building was opened by the Princess Royal in 2016.

The Royal Bournemouth Hospital also provides district-wide services for cardiac interventions, vascular surgery and urology. Outpatient clinics are provided for oral surgery, paediatrics, plastic surgery, ENT (ear, nose and throat), cardiothoracic and neurology.

**Christchurch Hospital**
Christchurch Hospital provides a pleasant environment for rehabilitation and a range of outpatient services. An all-age rehabilitation service has been developed, particularly in the award-winning and newly refurbished Day Hospital. Most patients are elderly, reflecting the local population. There is an excellent infrastructure to support rehabilitation with superb physiotherapy and occupational therapy facilities.

Outpatient clinics have expanded over recent years and include gastroenterology, breast, oncology and medicine for the elderly. Dermatology and rheumatology outpatient services are also provided at Christchurch Hospital together with phlebotomy (blood taking) services, diagnostic services and specialist palliative care (the Macmillan Unit).

## How we are run

As a Foundation Trust, we are accountable to NHS England and NHS Improvement. As the regulator for health services in England it oversees the governance and performance of the organisation, providing support where required, and ensures the Trust operates in line with the conditions of its provider licence. We are also accountable to local people through our Council of Governors and members.

In addition, there is a large range of inspection and other regulatory bodies which govern the activities of the Trust, including the Care Quality Commission (CQC). The CQC last inspected the Trust in March and April 2018. The report was published in June 2018 and the Trust was rated as 'Good' overall and 'Outstanding' for well-led and use of resources.

The Council of Governors, which represents around 10,000 members, is made up of members of the public, staff and appointed governors. They ensure members' views are heard and are fed back to our Board of Directors, and members of the public are kept up to date with developments within the hospitals. The RBCH Council of Governors ceased when the Trust ended on 30 September at the end of the period of this report and now we have a new University Hospitals Dorset Council of Governors following a new election. Details of this will be featured in the first part-year Annual Report for University Hospitals Dorset NHS Foundation Trust.

Our Board of Directors is made up of full-time executives, who are responsible for the day-to-day running of the organisation, and part-time non-executive Directors. The executive Directors work closely with the clinical leaders and managers throughout the hospitals in running the services. The Board also works closely with the Council of Governors.

The Trust is organised under three clinical care groups and a number of departments providing support services. We also work closely with a range of key health and social care partners to develop and deliver our services, such as clinical commissioning groups (CCGs) and social services. We are also part of the Dorset Integrated Care System (ICS).

# Estates and Capital Development 2020

**Operational Works**

Over the past several months the Estates team has focused on making the hospitals as safe as possible, due to the impact of Covid-19. Like many departments we have had high levels of self-isolation, coupled with many requests for changes to make the hospital's physical environment Covid-19 safe, in line with the ever changing guidance. The team has worked incredibly hard to maintain business as usual during this time, with staff supporting other departments as requested. It has been a challenge to keep the hospital environment safe, without compromising statutory demands. The latest ISO 9001 audit showed compliance with all the key standards on the RBCH sites. Their Quality Management System will be deployed across the whole UHD estates over the next 12 to 18 months.

Earlier in the year we started to work on plans to merge the estates department, ahead of the official merger on the 1 October 2020. The Estates leadership team merged 1 July 2020. This helped us to work closely with the Capital Team designing and developing plans for the reconfiguration of the estates to support the CSR changes. The new Estate's management structure will strengthen the Operational Estates department, drawing on the extensive knowledge and experience of diverse professionals.

Looking forwards to 2021 and beyond, the NHS Net Zero Carbon requirement will provide many opportunities to challenge the way we deliver services, with carbon reduction playing an important part in many of the decisions we make. Both Poole and RBCH have a good history of delivering sustainable and carbon reduction strategies and are well placed to continue this work, albeit at a greater scale in the future.

**Capital Works**

The capital teams have combined across all sites since July to provide one workforce. During the Covid pandemic the teams have undertaken various segregation projects to allow the hospital to continue to function, responding to the clinical need. The Trust has secured additional funding to prepare ED and other services for the on-going changes to support service delivery and these works have started on site.

Across Bournemouth and Poole the preparation work to implement the Clinical Services Review work to create a major emergency care facility at RBH and a major planned care facility at Poole continues, including securing planning approvals.

Works at RBH have been on-going with the development of the MCEC (Maternity, Children's and Emergency Centre). Enabling packages have been developed to clear the site and these works will commence on site shortly to relocate the main entrance and relocate services from the Atrium in anticipation of the MCEC.


The IT frame room relocation is currently underway. Works to provide new interventional radiography, along with replacement of an MRI scanner are about to start on site and development of a new state of the art pathology unit is on-going.

## NEW PATHOLOGY HUB

Works have also been progressing at the Christchurch site with rationalisation of current estate; this includes the development of proposals for a new Macmillan unit, with an increase of single rooms and increased facilities in both size and service. Therapy services have been relocated from Royal Bournemouth Hospital and works have been started to create new gym facilities and office accommodation. Options are being developed with regard to other services that can be relocated to the site.

Overall rationalisation of the site will release areas that could be developed with a joint venture partner to provide additional senior living accommodation and conclude the overall Christchurch Masterplan.

## CHRISTCHURCH HOSPITAL MASTERPLAN


Backlog maintenance investment across all sites continues with lifts, boilers, lighting replacement, door replacement, flooring, windows, electrical and water infrastructure improvements. Works have also been undertaken at Sterile Services Alderney, to replace flooring, undertake decorations and we plan to install two new washer disinfectors this year.

It has been an incredibly busy period for the capital team, the impact of Covid has added to the pressures inherent in delivering such large and complex projects. The team has performed fantastically well, under very difficult circumstances, dealing with additional requests for work, an influx of additional national funding, and supporting the Trust to deliver patient care safely and efficiently.

**Sustainability**

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve and to protect the environment which sustains them. Our aim to improve the health and resilience of communities, in the immediate and the long term, drives our efforts to is embed sustainably across the organisation.

This includes a commitment to responsible management of energy and water consumption and carbon emissions, a sustainable procurement strategy; a transport and active travel policy designed to reduce the negative environmental, health and social impacts of transport and reduce our carbon footprint; a range of waste reduction and recycling initiatives as well as a proactive staff engagement and communications strategy. The Trust also has a dedicated sustainability officer acting as the key contact within the Trust for all related enquiries, as well as promoting actions that the Trust is taking to reduce carbon emissions.

## Operational Performance 2020

### 1.1 How we measure performance

We measure our performance using the NHS Oversight Framework 2019/20. This framework has five themes:

1. Quality of care (safe, effective, caring, responsive)
2. Finance and use of resources
3. Operational performance
4. Strategic change
5. Leadership and improvement capability (well-led)

We report our performance to the Trust Board on a monthly basis and we are also monitored by NHSE/I. The Integrated Quality and Performance Report, our monthly performance summary, provides the Board with an overview of latest performance against the key metrics. It identifies exceptions, where performance has outperformed usual tolerances, or where it is falling short. Within the NHS Oversight Framework are key constitutional standards, set out within the NHS Constitution as standards which we pledge to achieve. Whilst pledges are not legally binding, they represent a commitment by the NHS to provide comprehensive high quality services. The Royal Bournemouth and Christchurch Hospitals has a track record for strong performance against national and local standards, and we are proud of the performance indicators we have again achieved this period, despite the challenges of Covid.

Our Audit Committee considers the Trust to be operating effectively in delivering good clinical, operational and financial performance and its key strategic objectives to implement Dorset's Clinical Services Review and the merger with Poole Hospital NHS Foundation Trust within a national context of significant concerns around funding, staffing, increasing inequalities and pressures from a growing and ageing population.

## 2.1 How we have performed during the first half of 2020/21

From March 2020 the focus of the Trust was redirected to first wave Covid–19 preparations and response. The planned response resulted in a reduction in elective capacity and increased waits for routine planned work, although overall numbers of people waiting fell due to reduced demand. The managed recovery following the first wave of the pandemic has included a focus on re-establishing all cancer and urgent activity and re-establishing routine elective activity safely. This was whilst complying with national infection control guidance and the use of Personal Protective Equipment (PPE) and social distancing. Complying with all infection control guidance has resulted in less activity being undertaken in re-established outpatient, procedure and theatre sessions for some specialities. These measures have impacted on the performance reported against the operational standards.

Up until the end of September 2020, the demand for elective care has not grown in 2020/21 year to date. Post the first wave of Covid-19 the levels of activity in both elective in-patient and outpatients have increased over the first half of the year, however, they remain below the same period in 2019/20 due to the impact on capacity of the Covid-19 response measure described above. Delivering the Referral to Treatment (RTT) 18 week access standard has remained challenging as a result of constraints in capacity due to staffing and compounded by the pandemic. Recovery and restoration action plans have been developed to improve performance against the 18 week access standard, with a particular focus on 52 week plus waiters. Whilst the Trust continues to need to meet the demands of COVID–19, all available operating capacity is allocated to time dependent surgery impacting on waiting times for routine planned surgery.

Delivery of performance against the DM01 diagnostic access standard of 99% of waits within 6 weeks, during the first half of the year has seen a strong recovery. However performance in September 2020 was lower than in 2019/20. For cancer, the 62 day standard and the majority of other cancer standards were not met at the end of September, although the service did achieve the Cancer 31 day standard. Diagnostic waits and late referrals have been contributing factors alongside reduced surgical capacity.

For RBCH site ED, despite reduced ED attendances and admissions in the first half of 2020/21 overall ED performance has been challenging, with Covid-19 significantly impacting on department capacity for suspected Covid patients and flow. This has resulted in capacity challenges and restricted flow to the hospital from the department. As a result performance against the 4-hour standard is lower than 2019/20.

## 2.2 Clinical Performance

| Performance Metric | National Target | RBCH Performance last year 2019/20 | RBCH Performance this period to Sept 20 |
|---|---|---|---|
| A&E - % patients admitted, transferred or discharged within 4 hours | 95% | 80.2% | 77.6% |
| Diagnostics – % patients seen within 6 weeks | 99% | 81.5% | 64.1% |
| Referral to Treatment - % patients within 18 weeks | 92% | 74.4% | 54.1% |
| Referral to Treatment – number of pathways | Zero growth | 27,979 | 27,922 |
| Cancer - % patients seen within 2 weeks from referral to first appointment | 93% | 62.10% | 57.9% |
| Breast Cancer - % patients seen within 2 weeks from referral to first appointment | 96% | 89.70% | 54.0% |
| Cancer - % patients diagnosed being treated within 31 days | 85% | 99.50% | 90.9% |
| Cancer - % patients being seen 62 days from urgent GP referrals | 85% | 84.50% | 71.8% |
| Cancer - 28 day Faster Diagnosis Standard | 85% | | 64.5% |

**Debbie Fleming**, Joint Chief Executive, 28 April 2021

# Accountability Report

## Directors' Report

### Board of Directors

The Board of Directors is made up of seven executive Directors and seven non-executive Directors, including the Chairperson. In addition, the Director of Improvement and Organisational Development, Deborah Matthews, attends meetings of the Board of Directors in a non-voting capacity.

The Board of Directors has given careful consideration to the range of skills, expertise and experience required for the running of the Trust and confirms that it has the necessary balance and the required range of skills, expertise and experience has been in place during the period under report.

The members of the Board of Directors from 1 April 2020 - 30 September 2020 are listed below.

## Non-Executive Directors

### David Moss, Chairperson

David has extensive experience of working within the NHS and the local region, having previously been Chief Executive Officer of both Poole Hospital and then University Hospital Southampton NHS Foundation Trusts. While at Southampton, David led the reconfiguration of the acute services over 10 hospitals and the creation of University Hospital Southampton. Southampton became a three star status Trust under his leadership. Other roles he has held include Director of Finance for East Dorset Health Authority, Deputy Director of Human Resources for the NHS and Chief Executive of the Royal College of Physicians.

David has also been a non-executive Director of the Audit Commission and Chair of the Board of Governors at Ferndown Upper School.

In January 2019 David was appointed as joint interim Chair of both Poole Hospital and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trusts. David chairs both nomination and remuneration committees at the Trust and the Shadow Interim Board which was established as part of the merger process to oversee the creation of the joint organisation and replaces the One Acute Network East Reconfiguration Board. David also regularly attends meetings of other committees of the Board of Directors.

### Pankaj Davé, Non-executive Director

Pankaj Davé returned to the Trust as a non-executive Director on 1 September 2018. Pankaj is a Chartered Certified Accountant and has worked internationally as a senior executive leading large multi-disciplinary teams for a range of internationally recognised businesses including BP, Amoco and Reliance Industries in strategy, financial, commercial, business transformation, operations, enterprise systems and planning and performance management roles. Pankaj has also been a trustee for Kidney Research UK and ran his own strategy consultancy business. He has recently returned to the UK after working in Mumbai for five years for Reliance Industries, India's largest company. As a direct report to the Managing Director, Pankaj led and successfully delivered a major group-wide transformation program to integrate processes, systems, data, organisation and governance. Pankaj is also a Lay Trustee on the Board of the Royal College of Surgeons (England) and is the Chair of their Audit and Risk Committee.

Pankaj chairs the Charitable Funds Committee and is a member of the Finance and Performance, Healthcare Assurance and Workforce Strategy and Development Committee.

### Christine Hallett, Non-Executive Director

Christine joined the Board of Directors in June 2015. Christine worked at the Department of Health for four years before moving into academia. She taught and researched in social policy at the universities of Oxford, Keele, Western Australia and Leicester. She served as Principal and Vice-Chancellor at the University of Stirling from 2003-2010. She has also served as a Civil Service Commissioner, as a Trustee of the National Centre for Social Research, as Chair of the Board of Trustees of the U.K. Council for International Student Affairs and as a member of the Board of Governors at Bournemouth University. Christine chairs the Healthcare Assurance Committee, is a member of the Audit Committee and is the Senior Independent Director (SID).

### Alex Jablonowski, Non-Executive Director

Alex joined the Trust's Board of Directors as a non-executive Director in June 2016. Alex has 25 years' board level experience within Barclays and government, including the Supreme Court, House of Commons, Ministry of Defence, Department for Transport, Government Actuary's Department, Companies House and the Office for National Statistics. He is a seasoned full-time UK independent government Director with extensive Chair, Board and Audit Committee experience. Alex has an MA(Hons) in Modern Russian Studies and is an Associate of the Chartered Institute of Bankers. Alex chairs the Audit Committee and is a member of the Finance and Performance Committee.

### John Lelliott OBE, Non-Executive Director

John joined the Trust's Board of Directors as a non-executive Director on 1 June 2016. John had a long career in public service retiring from The Crown Estate in September 2016 after over 30 years where he held the position of Finance Director. John is a Non-Executive Director of the Covent Garden Market Authority and non-executive board member of the Environment Agency. John was a Trustee and Vice Chair of Asthma UK until June 2017.

In July 2019 John became a Non-Executive Director of The Capitals Coalition and is the Chair of the ACCA Global Sustainability Forum, member of HRH The Prince of Wales Accounting for Sustainability Project (A4S) Advisory Council.

John is a qualified Chartered Certified Accountant and a member of the Chartered Association of Certified Accountants. John chairs the Finance and Performance Committee at the Trust and is a member of the Audit Committee and the Charitable Funds Committee.

### Iain Rawlinson, Non-Executive Director

Iain Rawlinson was appointed as a non-executive Director on 1 October 2017. Iain is a qualified barrister and holds a number of appointments in the business and charitable sectors. He spent much of his early career in the banking and investment sectors, and more recently has been involved in a broad range of business and charitable projects through leadership, advisory and non-executive Director roles. Alongside consulting on strategy and communications, Iain is Chair of the Development Board of Tusk Trust, a charity which protects wildlife, supports communities and promotes education in Africa, and is Chair of Governors at Walhampton School at Lymington. He is also a non-executive Director at Eurasia Mining PLC. Iain is a member of the Audit, Charitable Funds and Finance and Performance Committees. Iain was also a member of the Workforce Strategy and Development Committee until November 2019.

### Cliff Shearman, Non-Executive Director

Cliff Shearman was appointed as a non-executive Director in April 2017. Cliff was a Professor of Vascular Surgery/ Consultant Vascular Surgeon at University Hospital Southampton NHS Foundation Trust until 2016, where he was also Associate Medical Director. He was Head of the Wessex Postgraduate School of Surgery from 2007 to 2012. Cliff is now Emeritus Professor of Vascular Surgery at the University of Southampton.

Cliff has been heavily engaged in quality improvement work relating to people with diabetes to improve the quality of care and reduce vascular complications which can result in foot and leg amputations. He has also maintained an active research programme throughout his career leading various studies and publishing national and international guidelines, books, papers and articles. Cliff has represented the Vascular Society on the Royal College of Surgeons of England Council since 2015, and in April 2018 was elected as its Vice President. Cliff chairs the Workforce Strategy and Development Committee and is a member of the Healthcare Assurance Committee.

## Executive Directors

### Debbie Fleming, Chief Executive

Debbie Fleming has been Chief Executive of Poole Hospital since April 2014 and was appointed as interim joint Chief Executive of both Poole Hospital and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trusts in January 2019.

Debbie has over 30 years' experience in the NHS and began her NHS management career at Poole Hospital, enjoying 10 years as the Trust's general manager for medicine during the 1990s. She joined Poole Hospital from NHS England, where she served as area Director for Wessex, and has also held a variety of other senior posts within the NHS including more than a decade in Chief Executive roles at Bournemouth, Poole and Hampshire Primary Care Trusts. Debbie is also a member of Wimborne Academy Trust.

### Karen Allman, Director of Human Resources

Karen was appointed Director of Human Resources in 2007. She joined the NHS in 2003 from the Audit Commission where she was HR Director for District Audit. Her early career was spent in the private sector in retail with Marks & Spencer plc and Fenwick Limited before working in the City at the London Stock Exchange plc. Karen is also responsible for communications.

### Peter Gill, Director of Informatics

Peter has been Director of Informatics since 2012 and is responsible for the shared informatics service which also serves Poole Hospital NHS Foundation Trust. He has held two previous Informatics Director roles for a total of eight years in London and was Head of Informatics at Salisbury Foundation Trust for two years. He has been working in the NHS continuously from 1991 when he joined as a general management trainee. Peter is responsible for delivering the Informatics Strategy which aims to improve patient safety by implementing paperless healthcare.

### Alyson O'Donnell, Medical Director

Alyson was a Consultant Neonatologist in Southampton from 2000 until joining the Trust as Medical Director in November 2016. She was the Clinical Director for Family Health and Supporting Services from 2009-16 where she led Southampton Children's Hospital, Princess Anne Hospital (Maternity and Women's Health Services) as well as clinical and non-clinical support. During this time she was a member of the Trust Executive Committee and supported the Medical Director in a number of roles.

In addition, Alyson has held a number of strategic roles. She was the Clinical Lead for the Wessex Neonatal Network from its origins in 2003 until 2009 where she supported the implementation of the revised standards for neonatal care. More recently she has held the position of Clinical Director of the Wessex Maternity, Children's and Young People's strategic clinical network from 2013 until taking up her appointment with the Trust.

### Pete Papworth, Joint Interim Director of Finance

Pete was appointed as Director of Finance in May 2017 following five years as the Trust's Deputy Director of Finance and was appointed as interim joint Director of Finance of both Poole Hospital and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trusts in October 2019. Pete is a chartered accountant and brings 14 years' experience working across all aspects of the public sector in Dorset, since joining the Audit Commission's Graduate Scheme in 2003.

### Richard Renaut, Chief Operating Officer

Richard has been Chief Operating Officer since September 2014. He is responsible for the three clinical care groups that provide the clinical services across the Trust. He is also executive lead for estates, facilities and emergency and business planning. From 2006-2014 Richard was on the Board as Executive Director of Service Development, covering strategy, communications, estates, contracting and information. He joined the NHS through the NHS management training scheme and has worked in both primary care and tertiary hospital settings. Prior to his joining the Board Richard was General Manager of the Orthopaedic Directorate.

### Paula Shobbrook, Director of Nursing and Midwifery and Deputy Chief Executive

Paula joined the Trust as Director of Nursing and Midwifery in September 2011. Previously Director of Nursing at Winchester Hospital where she worked for 10 years, Paula's NHS career includes working as a ward sister in acute medicine, cardiac and respiratory specialties. She also spent some time working in primary care before moving back into a hospital setting.

Paula was appointed Deputy Chief Executive for RBCH in 2014.

Each Director has declared their interests at public meetings of the Board of Directors. The register of interests is available on the Trust's website.

Paragraph B.1.2 of The NHS Foundation Trust Code of Governance provides that at least half the Board of Directors, excluding the Chairperson, should comprise non-executive Directors determined by the board to be independent. The Trust is not currently compliant with this paragraph and its constitution provides for equal numbers of executive and non-executive Directors. This is permitted by the Model Core Constitution for NHS Foundation Trusts. The importance of ensuring a strong independent voice on the Board of Directors is supported

by other provisions of the Trust's constitution and the standing orders of the Board of Directors including the quorum for meetings of the Board of Directors, which requires that six Directors are present including not less than two executive Directors and two non-executive Directors, one of whom must be the Chairperson or the Vice-Chairperson of the board. In addition, the Chairperson has a second or casting vote in the case of an equality of votes and no resolution of the Board of Directors may be passed if it is opposed by all of the non-executive Directors present at the meeting.

### Role of the Board of Directors

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. The Board of Directors is responsible for setting and delivery of the Trust's objectives and wider strategy as well as monitoring the performance of the Trust. Its role also includes managing the risks associated with delivery of the objectives and priorities that have been set in the context of the overall risk management framework for the Trust. Much of the day-today work is done by the executive Directors, who work closely with the medical, nursing and operational leads of each of the Trust's three clinical care groups and the clinical Directors, senior nurses, ward sisters/charge nurses and other leaders throughout the organisation.

The Board of Directors clearly sets out the financial, quality and operating objectives for the Trust in the Trust's strategic objectives and quality priorities. The Board's business cycle ensures adequate systems and processes are in place to measure and monitor the Trust's performance and effectiveness, efficiency, economy and quality of healthcare delivery. Relevant metrics have been developed to assess progress and delivery of performance.

The Board of Directors also works closely with the Council of Governors to ensure that the interests of patients and the local community are represented.

The Board of Directors has six committees: Audit Committee, Charitable Funds Committee, Finance and Performance Committee, Healthcare Assurance Committee, Nomination and Remuneration Committee and Workforce Strategy and Development Committee. The members of each committee are also members of the Board of Directors.

The Board of Directors established a committee which meets together with the Board of Directors of Poole Hospital NHS Foundation Trust as the One Acute Network East Reconfiguration Board. The members of the committee are David Moss, Alex Jablonowski, John Lelliott and all the executive Directors of the Trust. Meetings are also attended by the Director of Improvement and Organisational Development, the One Acute Network Programme Director and the Lead Governor. The One Acute Network Reconfiguration Board was replaced by the establishment of the Shadow Interim Board in January 2020 as part of the merger process.

### Board meetings

The Board of Directors meets every other month on the last Wednesday of the month and at other times as necessary. The first part of the meeting is open to the public and members of the public are only excluded from meetings where the business to be transacted is confidential. The discussions and decisions relating to all items on the agenda of the Board of Directors meetings are recorded in the minutes of the meeting.

During the reporting period as a result of the Covid-19 pandemic and government guidance the Board of Directors took the decision not to hold board meetings in public; however the frequency of the private board meetings was increased to transact business and ensure there was oversight of performance and regulatory matters. Board meetings were also held jointly with the Board of Directors of Poole Hospital NHS Foundation Trust to help facilitate the upcoming merger of the two Trusts. Public papers were replaced by a Chief Executive report which was made available on the Trust's website. All meetings of the Board were held virtually using Microsoft Teams.

Opposite each name in the table below is shown the number of meetings at which that Director was present and in brackets the number of meetings that the Director was eligible to attend. The number of meetings includes both scheduled and special/ extraordinary meetings.

| Attendance at Meetings of the Board of Directors | | |
|---|---|---|
| **Name** | **Title** | **Attendance** |
| Karen Allman | Director of Human Resources | 8 (8) |
| Pankaj Davé | Non-Executive Director | 8 (8) |
| Debbie Fleming | Joint Interim Chief Executive | 8 (8) |
| Peter Gill | Director of Informatics | 6 (8) |
| Christine Hallett | Non-Executive Director | 8 (8) |
| Alex Jablonowski | Non-Executive Director | 8 (8) |
| John Lelliott | Non-Executive Director | 8 (8) |
| David Moss | Joint Interim Chairperson | 8 (8) |
| Alyson O'Donnell | Medical Director | 6 (8) |
| Pete Papworth | Joint Interim Director of Finance | 8 (8) |
| Iain Rawlinson | Non-Executive Director | 8 (8) |
| Richard Renaut | Chief Operating Officer | 8 (8) |
| Cliff Sherman | Non-Executive Director | 8 (8) |
| Paula Shobbrook | Director of Nursing and Midwifery | 8 (8) |

### Non-executive Directors

Non-executive Directors are appointed by the Council of Governors following a selection process through its Non-Executive Director Nomination and Remuneration Committee. Non-executive Directors are appointed for an initial term of three years and any subsequent re-appointment, subject to approval by the Council of Governors, is for a maximum term of three years.

Paragraph B.7.1 of The Foundation Trust Code of Governance specifies that any term of appointment beyond six years (e.g. two three-year terms) for a non-executive Director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the Board of Directors. It also sets out that non-executive Directors may serve longer than six years (e.g. two three-year terms following authorisation of the NHS Foundation Trust) but subject to annual re-appointment. All of the current non-executive Directors have been appointed for a maximum term of three years and were expected to continue until the merger of the Trust with Poole Hospital NHS Foundation Trust.

The Chairperson was determined to be independent upon appointment in 2017 and on appointment as joint Chair of the Trust and Poole Hospital NHS Foundation Trust in January 2019. All of the other non-executive Directors are considered to be independent.

Where appropriate, and as required, the Chairperson and the non-executive Directors meet without the executive Directors present.

The terms of office and the period of appointment of the non-executive Directors is set out in the table below. These appointments and reappointments were approved by the Council of Governors.

| Non-Executive Director | Appointed | Term of office |
|---|---|---|
| Pankaj Davé | 1 September 2018<br>Reappointed on 1 September 2019 | 1 year<br>2 years |
| Christine Hallett | 29 June 2015<br>Reappointed on 29 June 2018<br>28 April 2017 as Senior Independent Director | 3 years<br>3 years<br>2 years |
| Alex Jablonowski | 20 June 2016<br>Reappointed 20 June 2019<br>1 October 2017 as Vice-Chairperson<br>Reappointed on 1 October 2019 as Vice-Chairperson | 3 years<br>3 years<br>2 years<br>2 years |
| John Lelliott | 1 June 2016<br>Reappointed 1 June 2019 | 3 years<br>3 years |
| David Moss | 13 March 2017<br>(appointed as joint Chair of the Trust and Poole Hospital NHS Foundation Trust on 1 January 2019) | 3 years<br>3 years |

| | | |
|---|---|---|
| Iain Rawlinson | 1 October 2017 | 3 years |
| Cliff Shearman | 1 April 2017<br><br>Reappointed on 1 April 2020 | 3 years<br><br>3 years |

## Board evaluation

The performance of the non-executive Directors and the Chairperson was evaluated during the period in line with the Trust's appraisal process. The Chairperson led the process of evaluation of the non-executive directors and the Senior Independent Director undertook the evaluation of the performance of the Chairperson. Governors agree the evaluation processes for appraising the Chairperson and non-executive directors through the Non-Executive Director Nomination and Remuneration Committee and the outcome of both processes is shared with the Council of Governors. The Chairperson's appraisal incorporated the views of the directors and the governors. No separate meeting of the non-executive directors was held as part of the appraisal process for the Chairperson as specified in paragraph A.4.2 of The NHS Foundation Trust Code of Governance although feedback from the non-executive directors was provided as part the appraisal process.

The Chief Executive undertook performance appraisals of the executive directors and the Chief Executive's performance was appraised by the Chairperson. The objectives set for each of the executive directors were shared with the non-executive directors.

The Board of Directors, and each of its committees, evaluate its own performance annually and undertakes a more formal evaluation every three years. The process for committees includes a review against the committee's terms of reference to ensure that it is fulfilling its role and responsibilities and that these remain appropriate.

An external evaluation of the Board of Directors using the CQC's and NHS Improvement's well-led framework for leadership and governance reviews was undertaken in 2016/17. This review was supplemented by an internal review in 2017/18, again using the well-led framework. In April 2018, the CQC undertook an assessment of the Trust using the latest joint well-led framework for leadership and governance published in June 2017 and the Trust received an overall rating of 'Outstanding' from the CQC for the well-led domain.

The individual appraisals and performance evaluations of the Board of Directors and its committees were used as a basis to determine individual and collective professional development programmes for board members to enable them to discharge their duties more effectively.

## Audit Committee

The Trust's Audit Committee meets at least quarterly and representatives from the external auditor, internal auditors and the counter fraud service attend these meetings. The Director of Finance, Director of Nursing and Midwifery, Medical Director, Director of Informatics, Freedom to Speak Up Guardian and representatives from the risk management and clinical audit teams also regularly attend meetings at the request of the Chairperson. The Audit Committee met two times during the six months from 1 April 2020 to 1 October 2020. The committee members are all independent Non-executive directors and during the reporting period were:

| Name | Meetings attended |
|---|---|
| Alex Jablonowski (Chairperson) | 2 (2) |
| Christine Hallett | 2 (2) |

| | | |
|---|---|---|
| John Lelliott | 2 | (2) |
| Iain Rawlinson | 2 | (2) |

The Audit Committee's duties cover the following areas:

- reviewing the establishment and maintenance of an effective system of internal control, risk management and corporate governance, with particular reference to the Trust's Board Assurance Framework;
- appointing the internal auditors including the terms of appointment, agreeing the internal audit programme and reviewing the findings and recommendations from internal audit reports to provide assurance to the Board of Directors; considering the appointment of external auditors, including the terms of appointment, before making a recommendation to the Council of Governors, reviewing the nature and scope of the audit and the reports of the external auditors;
- considering the provision of any non-audit services to the Trust by the external auditors;
- appointing the counter fraud service including the terms of appointment, agreeing the counter fraud programme and reviewing the findings from investigations;
- monitoring management responses to internal audit, external audit and counter fraud reports and the implementation of recommendations;
- ensuring co-ordination between internal audit, external audit and the counter fraud service;
- ensuring that internal audit, external audit and counter fraud operate effectively, including appropriate resourcing and access to staff;
- reviewing the Annual Plan and Annual Report for clinical audit;
- reviewing the Annual Report, annual governance statement and annual financial statements before making a recommendation to the Board of Directors; and
- reviewing arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

### Internal audit

The Trust does not have an internal audit function but these services are provided by a third party provider of internal audit services which reports to the Audit Committee. The internal auditors, working with staff at the Trust and the Audit Committee, develop an audit plan each year based on the level of inherent risk and the strength of the control environment across the Trust. This forms part of a strategic three year plan for internal audit. Depending on changes in the risk profile of certain areas, all areas of the Trust should be considered during the internal audit cycle of three years. The Audit Committee approves the final plan, ensuring that the budget is available to meet the costs of delivering the plan. Internal audit is performed in accordance with best professional practice, in particular, NHS Internal Audit Standards and Public Sector Internal Audit Standards. The internal auditors were able to provide a moderate level of assurance, the second highest level, that there was a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.

### External audit

The Audit Committee formally reviews the work of the external auditor each year and communicates this to the Council of Governors to ensure that it is aware of the Trust's view on the performance of its auditors. In addition, the Audit Committee reviews the auditor's work plan for each year in advance.

The current external auditor, KPMG LLP, was first appointed by the Council of Governors for a term of three years from October 2015. In 2018, the Trust was part of joint procurement process for external audit services with Dorset Healthcare University NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust and Poole Hospital NHS Foundation. The process involved governors, non-executive directors and the finance directors from each Trust. The preferred supplier identified through this process was KPMG LLP and, in February 2018, the Council of Governors approved the appointment for KPMG LLP as the Trust's external auditor of the Trust for a period of five years from 1 October 2018. The committee approved the remuneration and terms of engagement for the external auditor and considered in detail the results of the audit for 2019/20, KPMG LLP's performance and independence and the effectiveness of the overall audit process.

### Non-audit services

The Audit Committee has approved a policy which governs the provision of non-audit services by the external auditors. The policy sets out limits on the services which may be provided by the external auditors so as not to impair their objectivity or independence when reviewing the Trust's financial statements but does not restrict the Trust from purchasing other services from the external auditors where this is in the best interests of the Trust. Any non-audit services provided by the external auditors are reported to the Audit Committee which is responsible for reviewing the objectivity and independence of the external auditors.

### Counter fraud

The Audit Committee is responsible for appointing the counter fraud service and ensuring it has appropriate support within the Trust to carry out its work. It reviews the annual counter fraud programme and the results of its proactive monitoring and awareness activities as well as reactive (investigations) work including management's response to recommendations, highlighting any issues to the Board of Directors if necessary. The committee ensures co-ordination between the internal auditors and counter fraud.

### Freedom to speak up (Whistleblowing)

The committee is responsible for the Trust's Freedom to Speak Up: raising concerns (whistleblowing) policy and has continued to support the work of the Trust's Freedom to Speak Up Guardian following her appointment in 2017/18. The Chair of the Audit Committee is the non-executive lead responsible for speaking up and meets regularly with the Freedom to Speak Up Guardian.

The Freedom to Speak Up Guardian reports to the committee annually on progress made to date in developing a culture of safety within the Trust so that it becomes a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely. This includes an overview of case referrals and the key themes identified from these.

### Significant areas

During the reporting period the Audit Committee continued to build its focus around risks and particularly those associated with the merger together with the review of reports from internal audit.

The committee ensures through its membership, which includes the chairs of the Healthcare Assurance Committee and the Finance and Performance Committee that the Board of Directors continues to have an effectively functioning committee structure providing it with the necessary assurance around key risks and the processes and controls to mitigate these. A governor attends all committee meetings to provide greater transparency on the work of the committee, recognising, in particular, the role of the Council of Governors in the appointment and removal of the external auditor.

The committee continued to maintain focus on a number of operational areas, which had been highlighted through internal audit reports and follow up reports including:

- the management of outpatient follow-up appointments in particular processes to prioritise and reduce the number of unnecessary follow-up appointments;
- consultant job planning and in particular the differences in good practice at both Poole Hospital and The Royal Bournemouth and Christchurch Hospitals NHS Foundation, to provide a more coherent approach ahead of the merger;
- coordinating the risk management processes of the Trust with those relating to the One Acute Network and the broader system in Dorset; and
- the review of sickness absence management.

The Audit Committee reviews the Annual Report and Accounts prior to their approval by the Board of Directors. The Chairs of the Healthcare Assurance Committee and the Finance and Performance Committee are members of the Audit Committee; they are able to provide details of scrutiny undertaken in these committees where it is relevant to issues considered by the committee. The Audit Committee also receives assurance from external sources including the internal auditors, external auditor and counter fraud specialist.

In carrying out its review of the Annual Report and Accounts, the Audit Committee provides assurance to the Board of Directors which supports the statement made by the Board that, taken as a whole the Annual Report and Accounts, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. Through its work and reporting to the committee by external sources, the Audit Committee considers the Trust to be operating effectively in delivering good clinical, operational and financial performance and its key strategic objectives to implement Dorset's Clinical Services Review and the merger with Poole Hospital NHS Foundation Trust within a national context of significant concerns around funding, staffing, increasing inequalities and pressures from a growing and ageing population.

No political donations were made.

## Going concern

International Accounting Standards (IAS1) require the directors to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 3.20, the accounts should be prepared on a going concern basis unless the directors either intend to apply to the Secretary of State for the dissolution of the Foundation Trust without the transfer of the services to another entity, or have no realistic alternative but to do so.

On 1 October 2020, Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust merged their operations into a single Trust, University Hospitals Dorset NHS Foundation Trust. On the same day, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust was dissolved. Whilst The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust is therefore not a going concern due to its dissolution as part of the merger, the financial statements of the Trust have been prepared on a going concern basis because its services are continuing to be provided by the successor foundation trust.

## Council of Governors

There are 27 members of the Council of Governors. The Council of Governors' principal duties are:

- to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors
- to represent the interests of the members of the Trust as a whole and the interests of the public.

The role and responsibilities of the Council of Governors are set out in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012). These have been incorporated into the Trust's constitution, standards of conduct and in the schedule of matters reserved for the Board of Directors.

During the reporting period the Council of Governors was made up as follows:

| **Public governors - Bournemouth and Poole constituency** | **Year elected** | **Term** |
|---|---|---|
| Judith Adda | 2019 | 3 years |
| Howard Fincher | 2019 | 3 years |
| Marjorie Houghton | 2017 | 3 years |
| Mark Howell | 2019 | 3 years |
| Keith Mitchell | 2017 | 3 years |
| Sue Parsons | 2016 | 1 year |
| Maureen Todd | 2017 | 3 years |
| David Triplow (Lead Governor from 12 April 2017) | 2017 | 3 years |
| Michele Whitehurst | 2017 | 3 years |

| **Public governors - Christchurch and Dorset County constituency** | **Year elected** | **Term** |
|---|---|---|
| Richard Allen | 2017 | 3 years |
| Colin Beck | 2019 | 3 years |
| Derek Chaffey | 2017 | 3 years |
| Eric Fisher | 2017 | 3 years |
| Kevin Steele (until April 2020) | 2019 | 3 years |
| Brian Young | 2017 | 3 years |
| Vacancy | | |

| **Public governors- New Forest and Rest of England constituency** | **Year elected** | **Term** |
|---|---|---|

| | | |
|---|---|---|
| Nick Harrison | 2017 | 3 years |
| John Lewis | 2019 | 3 years |
| Sandy Wilson | 2017 | 3 years |

| Staff governors | Staff class | Year elected | Term |
|---|---|---|---|
| Catherine Bishop | Administrative, Clerical and Management | 2017 | 3 years |
| Lucy Darke | Nursing, Midwifery and Healthcare Assistants | 2019 | 3 years |
| Marcus Pettit | Estates and Ancillary Services | 2017 | 3 years |
| Vacancy | Medical and Dental | | |
| Vacancy | Allied Health Professionals, Scientific and Technical | | |

| Appointed governors | Appointing organisation | Year appointed | Term |
|---|---|---|---|
| Michael Bowen (from September 2019) | The Royal Bournemouth and Christchurch Hospitals Volunteers Group | September 2019 | 3 years |
| Paul Hilliard | Bournemouth, Christchurch and Poole (BCP) Council | August 2019 | 3 years |
| Andrew Kerby | Dorset County Council | July 2019 | 3 years |
| Mufeed Ni'man (re-appointed September 2019) | NHS Dorset Clinical Commissioning Group | December 2016 | 3 years |
| Stephen Tee (re-appointed September 2019) | Bournemouth University | September 2015 | 3 years |

As at 30th September 2020 there were the following vacancies on the Council of Governors:

- Public governors - Christchurch and Dorset County Constituency- One vacancy
- Medical and Dental - One vacancy
- Allied Health Professionals, Scientific and Technical - One vacancy

## Meetings of the Council of Governors

The Council of Governors meets four times each year, usually in February, April, July and October and at other times as necessary. The first part of the meeting is open to the public. Due to the Covid-19 pandemic the public section of the meeting was cancelled and any meetings were held in private using Microsoft Teams in accordance with social distancing measures. Monthly informal governor briefings were held with the Chairperson, Chief Executive and non-executive directors supported by members of the executive team to ensure governors were kept up to date throughout the reporting period.

Against each name in the table below is shown the number of meetings at which the governor or director was present and in brackets the number of meetings that the governor or director was eligible to attend. The number of meetings includes both scheduled and special/ extraordinary meetings. The discussions and decisions relating to all items on the agenda of the Council of Governors meetings are recorded in the minutes of the meeting. Each governor has declared their interests at public meetings of the Council of Governors. The register of interests is available on the Trust's website and in the papers for each meeting.

| Name | Role | Constituency, class or appointing organisation | Attendance |
|---|---|---|---|
| David Moss | Chairperson | | 1 (2) |
| Judith Adda | Governor | Bournemouth and Poole | 2 (2) |
| Richard Allen | Governor | Christchurch and Dorset County | 1 (2) |
| Colin Beck | Governor | Christchurch and Dorset County | 2 (2) |
| Catherine Bishop | Staff Governor | Admin, Clerical and Management | 2 (2) |
| Michael Bowen | Appointed Governor | The Royal Bournemouth and Christchurch Hospitals Volunteers | 1 (2) |
| Derek Chaffey | Governor | Christchurch and Dorset County | 2 (2) |
| Lucy Darke | Staff Governor | Nursing, Midwifery and Healthcare Assistants | 2 (2) |
| Howard Fincher | Governor | Bournemouth and Poole | 2 (2) |
| Eric Fisher | Governor | Christchurch and Dorset County | 2 (2) |
| Nick Harrison | Governor | New Forest and Rest of England | 1 (2) |
| Paul Hilliard | Appointed Governor | Bournemouth, Christchurch and Poole (BCP) Council | 2 (2) |
| Marjorie Houghton | Governor | Bournemouth and Poole | 2 (2) |
| Mark Howell | Governor | Bournemouth and Poole | 2 (2) |
| Andrew Kerby | Appointed Governor | Dorset County Council | 1 (2) |
| John Lewis | Governor | New Forest and Rest of England | 2 (2) |
| Keith Mitchell | Governor | Bournemouth and Poole | 2 (2) |
| Mufeed Ni'man | Appointed Governor | NHS Dorset Clinical Commissioning Group | 0 (2) |

| | | | |
|---|---|---|---|
| Susan Parsons | Governor | Bournemouth and Poole | 2 (2) |
| Markus Pettit | Staff Governor | Estates and Ancillary | 0 (2) |
| Stephen Tee | Appointed Governor | Bournemouth University | 1 (2) |
| Maureen Todd | Governor | Bournemouth and Poole | 2 (2) |
| David Triplow | Lead Governor | Bournemouth and Poole | 2 (2) |
| Michele Whitehurst | Governor | Bournemouth and Poole | 2 (2) |
| Sandy Wilson | Governor | New Forest and Rest of England | 2 (2) |
| Brian Young | Governor | Christchurch and Dorset County | 1 (2) |

| Name | Role | Attendance |
|---|---|---|
| Karen Allman | Director of Human Resources | 1 (1) |
| Pankaj Davé | Non-Executive Director | 1 (1) |
| Debbie Fleming | Interim Joint Chief Executive | 2 (2) |
| Peter Gill | Director of Informatics | 0 (1) |
| Christine Hallett | Non-Executive Director | 1 (1) |
| Alexander Jablonowski | Non-Executive Director | 1 (1) |
| John Lelliott | Non-Executive Director | 0 (1) |
| Alyson O'Donnell | Medical Director | 0 (1) |
| Pete Papworth | Interim Joint Director of Finance | 1 (1) |
| Iain Rawlinson | Non-Executive Director | 0 (1) |
| Richard Renaut | Chief Operating Officer | 0 (1) |
| Cliff Shearman | Non-Executive Director | 0 (1) |
| Paula Shobbrook | Director of Nursing and Midwifery | 1 (1) |

### Elections

There were no elections held during the period 1 April 2020 – 30 September 2020

## Membership and engagement

During the period of this report membership engagement was severely curtailed due to the restrictions of Covid-19 and the demands across our services. This meant that most engagement with our Members was done through our own digital channels of communications and with our external PR with local and national media. Most of this was based on changes in our services, our response to the Covid pandemic and details about our visiting restrictions. There was also a lot of publicity leading up the merger of our Trust with Poole Hospital outlining the benefits to patients and to our region of our merger and the reconfiguration of our hospitals. See section below for more details on public engagement.

## Better Payment Practice Code

In accordance with the Better Payment Practice Code, the Trust aims to pay all valid invoices by their due date or within 30 days of receipt, whichever is the later. Performance currently benchmarks well and is set out below. The Trust did not incur any material liability to pay interest as a result of not paying any invoices within 30 days.

### Non-NHS payables

| | Number | Value |
|---|---|---|
| Total bills paid in the period | 26,554 | £78,118 |
| Total bills paid within target | 25,076 | £72,758 |
| Percentage of bills paid within target | 94.4% | 93.1% |

### NHS payables

| | Number | Value |
|---|---|---|
| Total bills paid in the period | 1,320 | £11,178 |
| Total bills paid within target | 1,226 | £8,701 |
| Percentage of bills paid within target | 92.9% | 77.8% |

### Total

| | Number | Value |
|---|---|---|
| Total bills paid in the period | 27,874 | £89,297 |
| Total bills paid within target | 26,302 | £81,459 |
| Percentage of bills paid within target | 94.4% | 91.2% |

References to 30 days include the due date if later.

## NHS Improvement's well-led framework

The Board of Directors has approved a leadership strategy that supports the delivery of the Trust's mission and strategic objectives as a well led organisation that delivers safe, high quality patient care that is clinically and financially sustainable. Through the strategy the board will oversee the creation of the leadership capabilities and leadership culture the organisation needs to possess in order to achieve its vision through the development of a leadership strategy. The leadership model for culture change will be one of collective leadership which will be clinically led. The board will promote the development of an inclusive leadership and management style.

Leadership capacity and capability is supported by management structures within the Trust. A care group model was introduced in 2014 together with some new roles: Directors of Operations and Heads of Nursing and Quality for each care group and Matrons and Directorate Managers at directorate level. In 2017, the Trust reviewed these structures further with a view to strengthening the clinical leadership model and embedding the triumvirate approach through care groups. By triumvirate we mean the three way partnership between the manager, the lead nurse or allied health professional and the lead doctor. This led to the introduction of a care group medical lead in each care group. The triumvirate take a collective responsibility for the delivery of services in their area and this is replicated at all leadership levels in the Trust. Leadership development programmes are provided for each of these groups.

The Board of Directors uses the well-led framework for leadership and governance reviews to assess its performance on annual basis. Further details on this process can be found in the Annual Governance Statement and the Directors' Report.

## Private patient income

The Trust has met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purpose of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

## Board's responsibility for the Annual Report and Accounts

The Directors are required by the National Health Service Act 2006 (as amended):

- to prepare, in respect of each financial year, annual accounts in such form as Monitor, now part of NHS Improvement, may, with the approval of the Secretary of State, direct; and
- to comply with any directions given by Monitor with the approval of the Secretary of State as to the methods and principles according to which the accounts are prepared and the content and form to be given in the accounts.

The accounts must provide a true and fair view and comply with International Financial Reporting Standards and the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2020/21. In preparing the annual report and accounts, the directors are required to:

- select suitable accounting policies and apply them consistently;
- make judgements and estimates that are reasonable and prudent; and
- prepare the annual report and accounts on the going concern basis, unless it is inappropriate to do so.

The Board has reviewed the Annual Report and Accounts, having taken into account all the matters considered by the Board and brought to the attention of the Board during the financial year. The Board consider that taken as a whole the Annual Report and Accounts, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

In the case of persons who are directors as at the date when this report is approved:

- so far as each of the directors is aware, there is no relevant audit information of which the Trust's auditor is unaware
- each of the directors has taken all the steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

This confirmation is given and should be interpreted in accordance with section 418 of the Companies Act 2006.

**Debbie Fleming**, Joint Chief Executive, 28 April 2021

# Learning from complaints and concerns

Under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, the Trust must prepare an annual report each year. This must specify the number of complaints received, the number of complaints which the Trust decided were well-founded and to summarise the subject matter of complaints, any matters of general importance arising from those complaints, or the way in which they have been managed and any actions that have been, or are to be taken to improve services as a consequence of those complaints.

Complaints made to the Trust are managed within the terms of the Trust's complaints procedure and national complaint regulations for the NHS. The overriding objective is to resolve each complaint with the complainant through explanation and discussion. Between 01 April 2020 to 30 September 2020 there were 169 formal complaints received and investigated by the Trust.

The focus of the Patient Advice and Liaison Service in resolving concerns informally with front line staff has been constructive but has also been an opportunity for some people to formalise their concerns as complaints. Underlying these changes has been a greater focus within the Trust on addressing complaints of all types and trying to identify how learning or changes in practice can best be integrated as widely as possible. More meetings have been offered to resolve the position and a sustained focus on closing complaints, and ensuring outcome actions and learning has taken place.

**Complaint outcomes**

There were 169 formal complaints reported into the Trust with appropriate apologies offered in the letter of response from the Chief Executive. Directorates are required to follow through changes resulting from upheld complaints within their own risk and governance meetings, recording these and reporting them into their governance meetings.

**Subjects of complaints**
The main categories of complaint were as follows:

| Subject | Formal complaints April 2020 to September 2020 | | Formal Complaints 2019/20 | | Formal Complaints 2018/19 | | Formal Complaints 2017/18 | |
|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % |
| Implementation of care – including quality, delays and/or complications of treatment | 80 | 47% | 200 | 40% | 173 | 41% | 122 | 39% |
| Clinical Assessment | 5 | 3% | 24 | 5% | 25 | 6% | 22 | 7% |
| Admission, transfer and discharge | 25 | 15% | 72 | 14% | 67 | 18% | 46 | 15% |
| Diagnostic tests (not pathology) | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Communication and consent | 50 | 29% | 171 | 34% | 131 | 31% | 105 | 34% |
| Medication | 2 | 1% | 11 | 2% | 13 | 3% | 7 | 2% |
| Security | 2 | 1% | 7 | 2% | 8 | 2% | 1 | 0% |
| Equipment | 0 | | 2 | 1% | 0 | 0% | 1 | 0% |
| Food Safety and Service | 1 | 1% | 1 | 0% | 1 | 0% | 0 | 0% |
| Visitor incidents/accidents | 0 | 0% | 1 | 0% | 0 | 0% | 0 | 0% |
| Treatment, procedure, care | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Staff incident | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Patient incidents (including falls, other accidents and self-harm) | 0 | 0% | 1 | 0% | 5 | 1% | 2 | 1% |
| Environment | 1 | 1% | 8 | 2% | 0 | 0% | 0 | 0% |
| Infection Control | 3 | 2% | 1 | 0% | 2 | 0% | 4 | 1% |

A proportion of complaint resolution meetings were held with complainants and key staff to assist with resolving complaints. The majority of these were effective in resolving concerns as advised by the complainants.

The PALS and Complaints team monitor emerging themes from complaints on a daily basis and discuss as a team ensuring escalation to the directorate or appropriate manager.

Any trends or themes identified are reported to the Deputy Director of Nursing. A full report on the themes from complaints is reported into the Trust Healthcare Assurance Committee meeting. Themes are then reviewed and triangulated with appropriate action taken

**Changes resulting from Complaints**

One of the main purposes in investigating complaints is to identify opportunities for learning and change in practice to improve services for patients. Examples of changes brought about through complaints are as follows and have been reported on the Trust website in period.

**You said** "I have been waiting for my procedure for a long time, I am in a lot of pain and my life is being compromised by the wait for my operation. Dorset didn't have a high prevalence of Covid-19 so why can't I be rescheduled imminently? Isn't the hospital back to 'normal"
**We did** "We are following Government and GMC and our focus is ensuring your safety. Owing to safety measures, we are not yet able to treat as many patients per day as we once did. If you are struggling, please contact your GP practice who may advise us of clinical changes and offer medication to help control your symptoms. You will not have to start your treatment programme again. We are working hard to offer you your treatment as soon as we safely can. PALS cannot expedite your treatment, they will liaise with the Orthopaedic Admissions team."

**You said** "I spoke with a member of staff who I do not think was listening to me and she was rude to me"
**We did** "Apologised and explained it was not the member of staff intention to cause upset"

**You said** "I was not prepared for the wait for my procedure; I was not expecting the level of pain that I felt and my pain should have been better managed."
**We did** "We learnt that communication was the key. We should have let you know that there was a delay but that the team caring for you were trying hard to work through a contingency plan to avoid cancelling the procedure. We recognise that our patient information could be improved to align expectation and as such we are developing a new leaflet to talk patients through what to expect so they can feel better informed going forward."

**Referrals to the Parliamentary and Health Service Ombudsman (PHSO)**
Complainants who remain dissatisfied with the response to their complaint at local resolution level were able to request an independent review to be undertaken by the Parliamentary and Health Service Ombudsman.

After receiving a response from the Trust, complainants are advised to contact the PHSO if they remain unhappy. Between 01 April 2020 to 30 September 2020 1 case was opened for investigation by the PHSO. We received the outcomes of two investigations and both were not upheld. This shows a decrease in the number taken to the PHSO and a decrease in the number upheld.

## Stakeholder relations

RBCH's stakeholders are numerous and varied, given the importance of healthcare to the population served. To better manage these the board's external well led review mapped those with a stake in RBCH's activities, assess the mechanisms and relationships and from there any additional actions for improvement.

The Council of Governors is a key forum, having governors directly elected from public and staff constituencies, and appointed from the two main local authorities, plus Bournemouth University and from volunteer groups.

Examples of stakeholder engagement include participation of the Chairperson and Chief Executive in the system leadership team for the Our Dorset Integrated Care System which includes local authorities, other NHS Trusts, commissioners and PCNs. Executive Directors attend a range of boards and groups, which oversee the delivery of NHS services, and the strategic intentions set out in the Dorset Sustainability and Transformation Plan.

The Health and Social Care Overview and Scrutiny Committee for BCP and Dorset Councils have had sight of the Trust's Quality Report and have been offered the opportunity to comment as well as receiving an update during the period. The Trust's Chief Executive, Medical Director and other staff also attended meetings of local authority health overview and scrutiny committees and council meetings. In Dorset and BCP the changes to local health services and the benefits for patients and the local population in Dorset's Clinical Service Review have also meant regular engagement with many stakeholders.

In the last year the NHS has developed a new GP infrastructure – Primary Care Networks (PCN) and we have been working closely with the Bournemouth and Christchurch PCNs particularly in responding to the COVID19 epidemic, as well as wider work in improving health.

Public support throughout the pandemic has been tremendous, and builds upon the already high levels of support, volunteering, donating and appreciation that RBCH's staff greatly value.

## Patient engagement

Our Quality Strategy details the aims, objectives, timescales, responsibilities and monitoring processes of how we will achieve high quality care for all. It is the driver for delivering healthcare that is safe, clinically effective and a positive experience for all those involved.

The national requirement for submission of the Friends and Family Test (FFT) data was paused during the Covid-19 pandemic. Despite this, the Trust continued to gather as much feedback from patients as possible whilst upholding infection prevention and control principles. Feedback was especially sought from NHS services that had been moved into different locations to continue elective care. NHS England and Improvement highlighted the Trusts drive to continue to collect feedback as a case study, highlighting good practice.

Audits and surveys have been adapted in response to infection control restrictions and a move to digital solutions have been utilised. Teams have been hosting online events to provide patients with health information.  Local feedback has been gathered, undertaken by Healthwatch, which identified the patient experience of healthcare during the pandemic and identified challenges and areas for improvement.

## Public and staff engagement

The Trust and its healthcare partners have continued with engagement activity, led by NHS Dorset Clinical Commissioning Group, to explain the changes happening to healthcare services in Dorset. This has included changes to the hospital estate, as part of reconfiguration of services.

Regular staff briefings continued to take place throughout the pandemic and were more important than ever. Led by our Joint Chief Executive and Joint Chair, these briefings became virtual via Teams and provided an additional communication channel for staff to hear about updates. Staff could ask the executive team questions and had responses straight away. These briefings also provided a progress report on the implementation of the Clinical Services Review, the establishment of the planned and emergency hospital sites and the merger, as well as providing an opportunity for staff to ask questions.

**Events**

Unfortunately our very popular calendar of events including the Open Day's and Understanding Health events were cancelled due to the pandemic.

**Reconfiguration engagement**

Due to the pandemic, traditional ways to engage with stakeholders were adapted to help communicate the timings around the planning applications for new building at the Royal Bournemouth site. 'Our Vision for the Future', a brochure packed with information and facts around the plans, was produced and sent out to MPs, councillors and members of the public who requested a copy. It was also promoted in the local media, via social media and available on the website.

**Newspaper Supplements** – RBCH worked with local health partners to produce a health supplement in the local newspaper. The supplement, distributed in the spring, updated the public on the healthcare in Dorset and the transformation over the coming years.

**Website** - The Trust website is regularly updated to keep the public up to date with changes in the Trust as well as what services are available and valuable information. Department contact details, information for patients, visitors and their carers as well as information for future staff are also easily accessible.

**Social Media** - Social media platforms have been used more than ever over the period to update the public and staff with Trust news and changes. The Trust Facebook page has over 8.7k likes and there are 8.3k followers on Twitter. Increasingly people want to ask questions or share an experience with us in this way. Direct messages through social media are answered during working hours and the platforms are a great way of engaging with the public.

**Videos through the pandemic** - 33 videos were produced and shared on social media and on our website throughout the pandemic. This was an effective way to get messages out quickly during a time when information and guidance was changing rapidly. Notable videos during this period include the 'Clap for Carers' event held at RBH as part of the national initiative, with Dorset Police and the fire service in attendance. The video went viral following a retweet by Good Morning Britain's Piers Morgan, with over 500k views and gaining almost 16k likes.

Other notable videos from this period include a 'guard of honour' series of films featuring patients applauded by ward staff following their discharge for Covid treatment. Public health messages were delivered by our ED consultants and Heads of Nursing to support Dorset CCG's 'Here For You'

campaign ahead of national holidays such as Easter Weekend and summer break, and a consultant surgeon's update on the resumption of services and non-urgent operations.

The videos all received a high volume of comments and compliments from public and staff alike, as well as local press, and we were able to respond to queries immediately.

**News releases and media enquiries**

**News releases:** Issuing news releases to the media between April and September 2020 enabled to Trust to communicate with a wide group of stakeholders including the media themselves. 21 news releases were sent out to the media during this time covering visiting guidance changes, ward moves due to covid and various other updates. This information was also sent over via our other communication channels.

**Media enquiries:** Between 1 April 2020 and 30 September 2020 57 media enquiries were taken and responded to. These covered a range of subjects but were mainly related to the pandemic.

National and local media visited the hospital many times between April and September and helped give a real insight into how the hospital and staff were coping. Any coverage TV or radio coverage was shared via social media and was very popular in terms of shares and likes.

**CEO video updates -** CEO Debbie Fleming has given a number of video updates throughout the period. Mainly aimed at staff, the You Tube videos are promoted via the intranet, and covered the pandemic, the merger and staff support.

# Remuneration Report

## Annual statement on remuneration

The Remuneration Report summarises our remuneration policy and, particularly, its application in connection with the executive directors. The report also describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration as defined in the NHS Code of Governance, in sections 420 to 422 of the Companies Act 2006 and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ('the Regulations') as interpreted for the context of NHS Foundation Trusts, Parts 2 and 4 Schedule 8 of the Regulations and elements of the Foundation Trust Code of Governance.

The Nomination and Remuneration Committee considers and acts with delegated authority from the Board of Directors on all matters concerning the remuneration, allowances and other terms of service of the Executive Directors. The Committee comprises of the Trust Chair and all Non-Executive Directors. The Committee is attended by the Chief Executive and others at the request of the Chair in an advisory capacity where appropriate.

Non-Executive Director's remuneration and terms and conditions of service are developed and reviewed periodically by the Council of Governors NED Nomination and Remuneration Committee and ratified by the Council of Governors.

All directors of the Trust are subject to individual performance review. This involves the setting and agreeing of objectives for a 12 month period running from 1 April to 31 March.

The full remuneration report of salary, allowances and benefits of senior managers are set out below.

Remuneration for Non-Executive directors is set out below and within the Full Statutory Accounts. No additional fees are payable in the role of Non-Executive director.

**Debbie Fleming**, Joint Chief Executive, 28 April 2021

**David Moss**
Joint Chairman, 28 April 2021

## Senior manager remuneration

| Senior manager remuneration | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | Title (as at 30 September 2020) | Six months ended 30 September 2020 | | | | | 2019/20 | | | | |
| | | Salary and Fees | Other Remuneration | Total Salary and Fees | Pension Related Benefits | Total | Salary and Fees | Other Remuneration | Total Salary and Fees | Pension Related Benefits | Total |
| | | (bands of £5000) £'000 | (bands of £5000) £'000 | (bands of £5000) £'000 | (bands of £2,500) £'000 | (bands of £5,000) £'000 | (bands of £5,000) £'000 | (bands of £5000) £'000 | (bands of £5000) £'000 | (bands of £2,500) £'000 | (bands of £5,000) £'000 |
| **Executive Members** | | | | | | | | | | | |
| Mrs D Fleming | Interim Joint Chief Executive (See note 1) | 45-50 | - | 45-50 | - | 45-50 | 101-105 | - | 101-105 | - | 101-105 |
| Mrs P Shobbrook | Director of Nursing and Midwifery | 71-75 | - | 71-75 | 15-17.5 | 86-90 | 146-150 | - | 146-150 | 80-82.5 | 226-230 |
| Mr P Papworth | Interim Joint Director of Finance (See note 2) | 36-40 | - | 36-40 | - | 36-40 | 106-110 | - | 106-110 | - | 106-110 |
| Mr R Renaut | Chief Operating Officer | 66-70 | - | 66-70 | 22.5-25 | 90-95 | 136-140 | - | 136-140 | 30-32.5 | 166-170 |
| Mrs K Allman | Director of Human Resources | 60-65 | - | 60-65 | 5-7.5 | 66-70 | 121-125 | - | 121-125 | 12.5-15 | 130-135 |
| Dr A O'Donnell | Medical Director (See note 3) | 90-95 | - | 90-95 | - | 90-95 | 186-190 | - | 186-190 | - | 186-190 |
| Mr P Gill | Director of Informatics (See note 4) | 31-35 | - | 31-35 | 7.5-10 | 41-45 | 61-65 | - | 61-65 | 7.5-10 | 70-75 |
| **Non-Executive Members** | | | | | | | | | | | |
| Mr D Moss | Interim Joint Chairperson (See note 5) | 11-15 | - | 11-15 | Not applicable | 11-15 | 26-30 | - | 26-30 | Not applicable | 26-30 |
| Mr C Shearman | Non-Executive Director (See note 6) | 6-10 | - | 6-10 | Not applicable | 6-10 | 11-15 | - | 11-15 | Not applicable | 11-15 |
| Mr DI Rawlinson | Non-Executive Director | 6-10 | - | 6-10 | Not applicable | 6-10 | 11-15 | - | 11-15 | Not applicable | 11-15 |
| Ms C Hallett | Non-Executive Director | 6-10 | - | 6-10 | Not applicable | 6-10 | 16-20 | - | 16-20 | Not applicable | 16-20 |
| Mr J Lelliott (OBE) | Non-Executive Director (See note 7) | 6-10 | - | 6-10 | Not applicable | 6-10 | 16-20 | - | 16-20 | Not applicable | 16-20 |
| Mr A Jablonowski | Non-Executive Director (See note 8) | 6-10 | - | 6-10 | Not applicable | 6-10 | 16-20 | - | 16-20 | Not applicable | 16-20 |
| Mr P Davé | Non-Executive Director (See note 9) | 6-10 | - | 6-10 | Not applicable | 6-10 | 11-15 | - | 11-15 | Not applicable | 11-15 |
| | | | | | | | | | | | |
| Band of highest paid director | | | | 201-205 | | | | | 201-205 | | |
| Median Total Remuneration | | | | 30,615 | | | | | 29,608 | | |
| Ratio | | | | 6.6 | | | | | 6.8 | | |

### Notes:

**1** Mrs D Fleming commenced her post as Interim Joint Chief Executive on 1st January 2019 and is not a member of the NHS Pension Scheme. Mrs Fleming is employed by Poole Hospital NHS Foundation Trust and the salary shown above represents the Trusts 50% contribution with effect from 1 January 2019.

**2** Mr P Papworth is employed by the trust and holds an Interim Joint Director of Finance post with Poole Hospital NHS Foundation Trust and previously opted out of the pension scheme on 31st May 2017. The salary above represents the Trust's 50% contribution after adjusting for the recharge to Poole Hospital NHS Foundation Trust for the remaining 50%.

**3** Dr A O'Donnell opted out of the pension scheme on 30th April 2017.

**4** Mr P Gill is employed by the Trust and holds a Joint Director of Informatics post with Poole Hospital NHS Foundation Trust. The salary shown above represents the Trusts 50% contribution, after adjusting for the recharge to Poole Hospital NHS Foundation Trust for the remaining 50%.

**5** Mr D Moss is employed by the Trust and was appointed as Interim Joint Chairperson with Poole Hospital NHS Foundation Trust with effect from 1st January 2019. The salary shown above is net of the 50% recharge to Poole Hospital NHS Foundation Trust with effect from 1 January 2019.

**6** Mr C Shearman commenced his post as a Non Executive Director on 1st April 2017. He was reappointed on 1st April 2020.

**7** Mr J Lelliott (OBE) commenced his post as Non Executive Director on 1st June 2016 and was reappointed on 1st June 2019.

**8** Mr A Jablonowski commenced his post as Non Executive Director on 20th June 2016 and was reappointed on 29th June 2018.

**9** Mr P Davé commenced his post as Non Executive Director on 1 September 2018 and was reappointed on 1st Septrember 2019.

**10** Senior manager remuneration does not include any 'annual performance-related bonuses' or 'long-term performance-related bonuses'. An increase was made with effect 1st April 2019, consisting of a flat rate payment in line with national recommendations. The flat rate was commensurate with the cash value of the 2019/20 award applied to agenda for change staff at the top of bands 8c, 8d and 9. The Joint Chair, Chief Executive and Director of Finance posts are interim linked to the merger of the two trusts.

**11** No individual named above received any significant benefit in kind during either financial period.

**12** No other categories in the proforma single figure table disclosure are relevant to the Trust.

**13** Of the 14 senior managers in the table above, 5 received expenses during the period amounting to a total of £637 after contributions from Poole Hospital NHS Foundation Trust. In 2019/20 10 received expenses amounting to £10,407 after contribution from Poole Hospitals NHS Foundation Trust.

**14** There are 23 governors (excluding staff governors), of which 4 received expenses during the period amounting to a total of £215. In 2019/20 8 governors received expenses amounting to £3,303.

## Summary of policy in relation to duration of contracts, notice periods; and termination payments:

- All Executive Directors are required to provide six months' written notice, however in appropriate circumstances this could be varied by mutual agreement.
- With the exception of the Interim Joint Chairperson, Interim Joint Chief Executive and Interim Joint Director of Finance, all senior manager contracts are permanent. Mr D Moss and Mr P Papworth hold permanent contracts with the Trust and interim contracts with Poole Hospital NHS Foundation Trust. Mrs D Fleming holds an interim contract with the Trust with her permanent contract held by Poole Hospital NHS Foundation Trust.
- All senior managers appointed on a permanent contract are required to provide three months' written notice.
- There are no payments for loss of office other than standard NHS redundancy provisions.

## Median Total Remuneration

The NHS Improvement Foundation Trust Annual Reporting Manual requires disclosure of the median remuneration of the reporting entity's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director.

The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. The September payments have been annualised and adjustments made for any outliers that would distort the results. Agency costs have been excluded from this calculation. The increase in the banding of the highest paid director is in line with the disclosures within the Remuneration Report.

**Debbie Fleming**
Joint Chief Executive, 28 April 2021

## Senior manager pension entitlements

| Name | Title (as at 30 September 2020) | Real Increase in Pension and Related Lump Sum at retirement age | Total accrued Pension and Related Lump Sum at retirement age at 30 September 2020 | Cash Equivalent Transfer Value at 30 September 2020 | Cash Equivalent Transfer Value at 31 March 2019 (Inflated) | Real Increase in Cash Equivalent Transfer Value | Employer-Funded contribution to growth in CETV for the year |
|---|---|---|---|---|---|---|---|
| | | (Bands of £2,500) | (Bands of £5,000) | £'000 | £'000 | £'000 | £'000 |
| Mrs D Fleming | Interim Joint Chief Executive (see note 2) | N/A | N/A | N/A | N/A | N/A | N/A |
| Mrs P Shobbrook | Director of Nursing and Midwifery | 0-2.5 | 211-215 | 1,141 | 1,099 | 41 | 31 |
| Mr P Papworth | Interim Joint Director of Finance (see note 3) | N/A | N/A | N/A | N/A | N/A | N/A |
| Mr R Renaut | Chief Operating Officer | 0-2.5 | 131-135 | 708 | 672 | 36 | 26 |
| Mrs K Allman | Director of Human Resources | 2.5-5 | 101-105 | 629 | 599 | 30 | 22 |
| Mr P Gill | Director of Informatics | 0-2.5 | 141-145 | 838 | 802 | 36 | 27 |
| Dr A O'Donnell | Medical Director (see note 4) | N/A | N/A | N/A | N/A | N/A | N/A |

### Notes:

1 Non Executive Directors do not receive pensionable remuneration, and as such, there are no entries in respect of pensions for Non Executive Directors.
2 Mrs D Flemming commenced her post as Interim Joint Chief Executive (with Poole Hospital NHS Foundation Trust) on 1st January 2019 and has opted out of the pension scheme.
3 Mr P Papworth commenced his post as Interim Joint Director of Finance (with Poole Hospital NHS Foundation Trust) on 1st October 2019 and opted out of the pension scheme on 31 May 2017.
4 Dr A O'Donnell opted out of the pension scheme on 30 April 2017.

The increase in the banding of the highest paid director is in line with the disclosures within the Remuneration Report.

## Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated as prescribed by the Institute and Faculty of Actuaries.

## Real Increase in CETV

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

**Debbie Fleming,**
Joint Chief Executive
28 April 2021

## Senior Managers' Remuneration Policy

| Future Policy Table | | | | | |
|---|---|---|---|---|---|
| **Item** | **Salary/Fees** | **Taxable Benefits** | **Annual Performance Related Bonus** | **Long Term Related Bonus** | **Pension Related Bonus** |
| **Support for the short and long term objectives of the Foundation Trust** | Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives | None disclosed | None Paid | None Paid | Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives |
| **How the component operates** | Paid in even twelfths | None disclosed | None Paid | None Paid | Employer and employee contributions |
| **Maximum payment** | As set out in the accounts | None disclosed | None Paid | None Paid | Contributions are made in accordance with the NHS Pension Scheme |
| **Framework used to assess performance** | Trust appraisal system | None disclosed | None Paid | None Paid | Not applicable |
| **Performance measures** | Tailored to individual posts | None disclosed | None Paid | None Paid | Not applicable |
| **Amount paid for minimum level of performance and any further level of performance** | Salaries are agreed on appointment and set out in the contract of employment | None disclosed | None Paid | None Paid | Not applicable |
| **Explanation of whether there are any provisions for recovery of sums paid to directors or provisions for withholding payments** | Any overpayments may be recovered | None disclosed | None Paid | None Paid | Not applicable |

Non-Executive Directors are appointed on fixed term contracts, normally three years in length, and they do not gain access to the Pension Scheme as a result of this engagement. The fee payable to Non-Executive Directors is set out later. They do not receive any other payments from the Trust.

### Service Contract Obligations

All Executive Directors are required to provide six months' notice, however in appropriate circumstances this could be varied by mutual agreement. With the exception of the Joint Interim Chief Executive, Joint Interim Chairman and Joint Interim Director of Finance all senior manager contracts are permanent. Mr David Moss and Mr Pete Papworth hold permanent contracts with the Trust and interim contracts with Poole Hospital NHS Foundation Trust. Mrs Debbie Fleming holds an interim contract with the Trust with her permanent contract held by Poole Hospital NHS Foundation Trust. All senior managers are employed on permanent or fixed term contracts and are required to give three

months' notice to terminate their contract. Terms of each of the non-executive directors are given in the details of the Board members above.

### Policy on payment for Loss of Office

Payment for loss of office is covered within contractual notice periods and standard employment policies and legislation. The Trust has made no provision for compensation for early termination and no payment for loss of office for senior managers.

### Trust's Consideration of Employment Conditions

Other members of staff who are not Board members are employed on agenda for change terms and conditions and any percentage pay increases are applied in accordance with national agreements. The Nomination and Remuneration Committee agrees very senior managers pay and conditions following consideration of benchmarking information on comparable roles.

### Service Contracts

All executive directors are employed on permanent or fixed term contracts

As stated above, all directors are subject to six months' notice period. The Trust Board Members Table below shows their start and finish dates, where applicable or if their role is current:

## Trust Board Members

| **Board of Directors** | | | | |
|---|---|---|---|---|
| **Executive Director** | **Title** | **Date of appointment** | **Contract date to** | **Notice Period** |
| Debbie Fleming | Joint Interim Chief Executive *(appointed Joint Interim Chief Executive of the Trust and Poole Hospital NHS Foundation Trust 1 January 2019)* | January 2019 | Current | 6 months |
| Karen Allman | Director of Human Resources | June 2007 | Current | 6 months |
| Peter Gill | Director of Informatics | November 2012 | Current | 6 months |
| Alyson O'Donnell | Medical Director | November 2016 | Current | 6 months |
| Pete Papworth | Director of Finance (Joint Interim Director of Finance from 01 October 2019) | May 2017 | Current | 6 months |
| Richard Renaut | Chief Operating Officer | September 2014 | Current | 6 months |
| Paula Shobbrook | Director of Nursing and Midwifery/Deputy Chief Executive | September 2011 | Current | 6 months |
| **Non-Executive Director** | **Title** | **Date of Appointment** | **Contract date to** | **Notice Period** |
| Pankaj Dave | Non-Executive Director | 1 September 2018 | 31 August 2021 | 1 month |
| Christine Hallett *(Senior Independent Director* | Non-Executive Director | 29 June 2015 | 28 June 2022 | 1 month |
| Alex Jablonowski *(Vice-Chairman)* | Non-Executive Director | 20 June 2016 | 19 June 2022 | 1 month |
| John Lelliott | Non-Executive Director | 1 June 2016 | 31 May 2022 | 1 month |
| David Moss | Chairman *(appointed Joint Interim Chair of the Trust and Poole Hospital NHS Foundation Trust on 1 January 2019 – 3 year appointment)* | 13 March 2017 | 31 December 2022 | 1 month |
| Iain Rawlinson | Non-Executive Director | 1 October 2017 | 29 September 2020 | 1 month |
| Cliff Shearman | Non-Executive Director | 1 April 2017 | 30 March 2023 | 1 month |

## Remuneration Committee

The Trust has two remuneration committees – The Board of Directors Nomination and Remuneration Committee and the Council of Governors NED Nomination and Remuneration Committee.

## Nomination and Remuneration Committees

The Nomination and Remuneration Committee is a committee of the Board of Directors with responsibility for:

- reviewing of the structure, size and composition of the Board of Directors;
- developing succession plans for the Chief Executive and other executive Directors, taking into account the challenges and opportunities facing the Trust;
- appointing candidates to fill vacancies amongst the executive Directors;
- reviewing remuneration and terms of conditions for executive Directors and very senior managers (those managers not on NHS agenda for change pay scales); and
- making recommendations to the Board of Directors for the award of discretionary points for consultants and specialist and associate specialist and staff grade doctors.

The Chairperson is the Chair of the Nomination and Remuneration Committee and its members are the remaining non-executive Directors, and the Chief Executive for any decisions relating to the appointment or removal of the executive Directors. The committee is also advised by the Chief Executive on performance aspects by the Director of Finance on the financial implications of remuneration or other proposals and by the Director of Human Resources on personnel and remuneration policy.

The Nomination and Remuneration Committee reviews national pay awards for staff within the Trust alongside information on remuneration for executive Directors at other trusts of a similar size and nature, taking account of overall and individual performance and relativities, with the aim of ensuring that remuneration of executive Directors is fair and appropriate. Through this process any salary above the threshold of £150,000 used by the Civil Service is considered and approved by the committee with a view to attractive and retaining individuals to support the Trust in delivering its vision and meeting its objectives.

There were no meetings of the Committee during the period 1st April 2020 to 30th September 2020.

## NED Nomination and Remuneration Committee

The Council of Governors' Nomination and Remuneration Committee is responsible for making recommendations to the Council of Governors on the following:

- Appointment and remuneration of the Chair and Non-Executive Directors
- Appraisal of the Chair
- Approval of appointment of the Chief Executive
- Succession Planning for posts of Chair and Non-Executive Directors

The Council of Governors Nomination and Remuneration Committee and its membership comprises of the Chair, the Lead Governor and 4 governors.

There were two meetings of the committee during the period 1st April 2020 to 30th September 2020 and the members' attendance is set out below:

| Name | Meetings attended out of possible total |
|---|---|
| David Moss, Chair | 2 / 2 |
| David Triplow, Lead Governor | 2 / 2 |
| Keith Mitchell, Deputy Lead Governor | 2 / 2 |
| Eric Fisher, Public Governor | 2 / 2 |
| Sue Parsons, Public Governor | 2 / 2 |
| Sandy Wilson, Public Governor | 2 / 2 |

The Trust Secretary services the committee and provides advice to the committee.

## Disclosures required by Health and Social Care Act

Remuneration for senior managers is set out within the Remuneration Report. For all other staff the Trust adheres to the national agenda for change guidelines for the setting of pay and notice periods.

The expenses of Directors and staff governors are reimbursed in accordance with the Trust's policy on expenses applicable to all staff. Travel and other costs and expenses for all other governors are reimbursed in accordance with a separate policy approved by the Nomination and Remuneration Committee, made up of the non-executive Directors. Governors are volunteers and do not receive any remuneration for their roles.

# Staff report

**Informing and consulting with our staff**

Consultation with staff has continued in order to bring together the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital Foundation Trust. This commenced with senior leaders and critical day one posts. However, there were some delays due to Covid-19, including deferment of merger from 1 June 2020 until 1 October 2020.

Consultations were carried out in accordance with the Trust's Organisational Change policy, with staff and their representatives being given an opportunity to comment and make alternative suggestions. The Trusts have also worked together to ensure consistency and fairness.

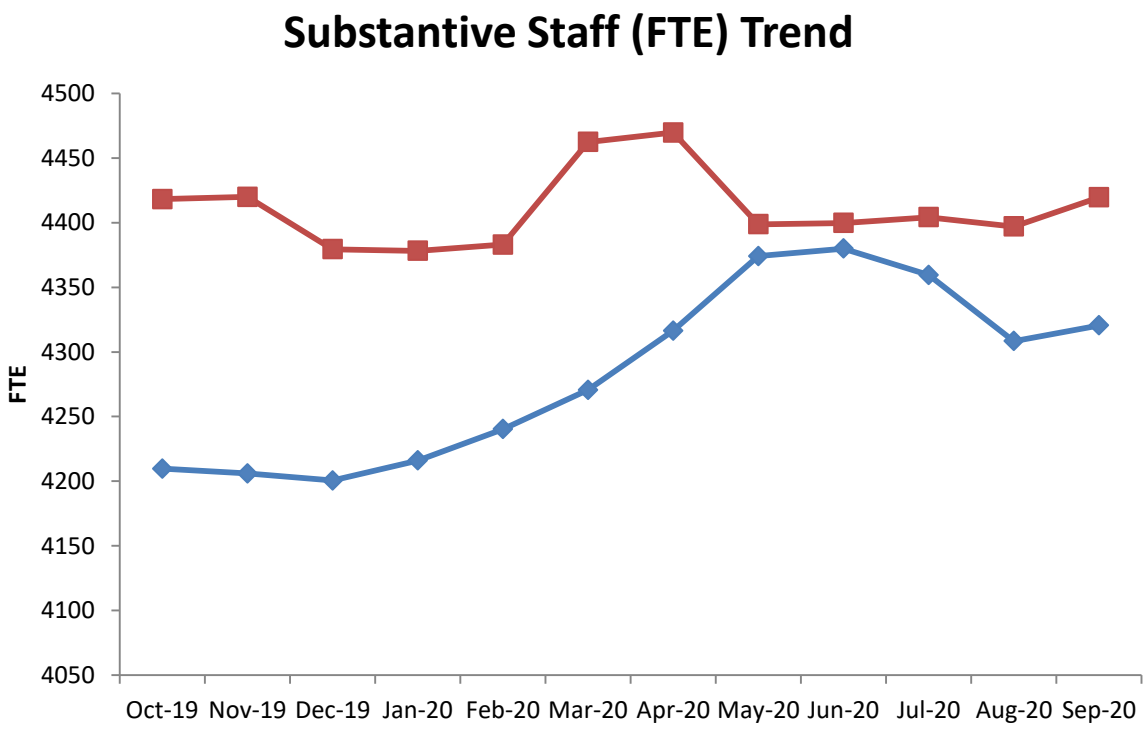
The Trust is committed to working closely with staff side organisations, with all formal consultations being presented at Partnership Group.

| Consultation | Number of staff affected | Date |
|---|---|---|
| Senior Leaders and 'Day one' posts, appointment of joint posts for the new organisation:<br>Deputy COOs<br>Group Directors of Operations<br>Deputy Chief Nursing Officer<br>Group Directors of Nursing<br>Deputy Chief Finance Officers<br>Associate Director of Finance<br>Associate Director of Business Information<br>Group Director of Midwifery<br>Infection Control Lead<br>Director of Pharmacy<br>Deputy Director of Pharmacy<br>IG and Data Protection Officer<br>Deputy IG and DP Officer<br>Deputy Medical Directors<br>Transformation Lead<br>Clinical Directors<br>Deputy Chief People Officers | 33 | Consultation launched 14 February 2020, completion June 2020. Delay due to Covid-19 |
| Heads of Commercial Services Appointment of joint posts for the new organisation. | 3 | August 20 launch (Completed November 2020) |
| Health Records – minor change to line management for the new organisation | | September 2020 |

**Staff numbers**

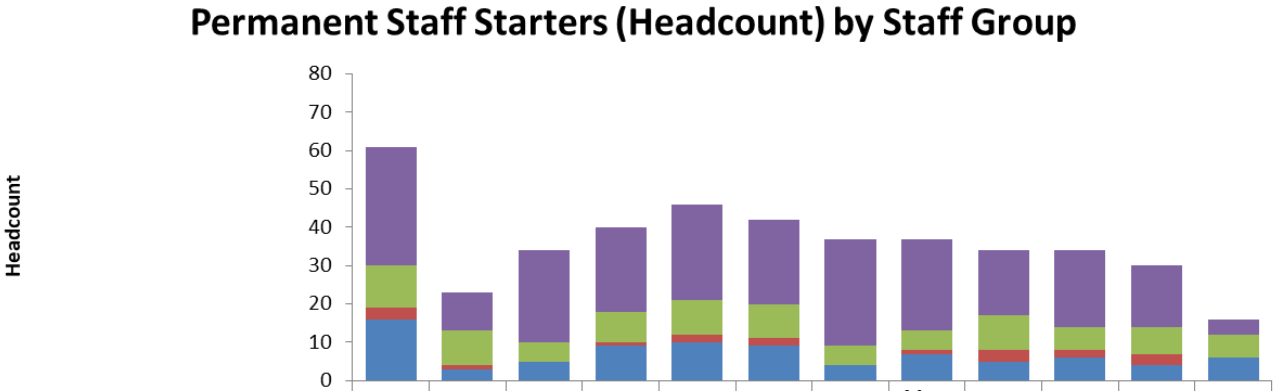
The number of full time equivalent employed at the end of September 2020 was 4,320.40, an increase since 31 March 2020 of 49.80.

The chart below shows an increase in numbers employed over the first wave of Covid-19 between April and July 2020. This was in response to additional clinical staff being required for the Covid-19 wards and also to back-fill the staff who were shielding due to Covid-19. The number remained within the funded budget.



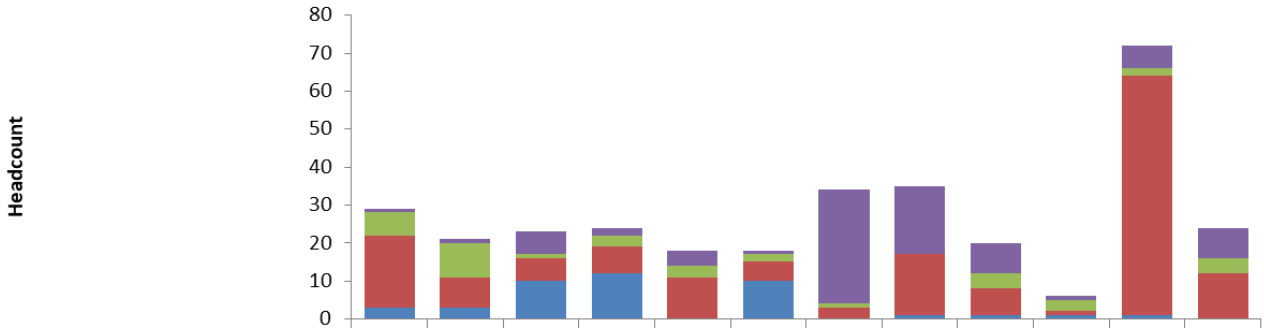

**Funded posts FTE** **In-post FTE**

New staff have been recruited into key vacancies, with normal increases showing in for medical staff on the fixed term chart in May and August 2020. Newly qualified nurses generally commence between September and October, the start of the recruitment campaign can be seen on the permanent starters chart in September 2020.




| | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Other | 31 | 10 | 24 | 22 | 25 | 22 | 28 | 24 | 17 | 20 | 16 | 4 |
| Administrative and Clerical | 11 | 9 | 5 | 8 | 9 | 9 | 5 | 5 | 9 | 6 | 7 | 6 |
| Medical and Dental | 3 | 1 | 0 | 1 | 2 | 2 | 0 | 1 | 3 | 2 | 3 | 0 |
| Nursing and Midwifery Registered | 16 | 3 | 5 | 9 | 10 | 9 | 4 | 7 | 5 | 6 | 4 | 6 |

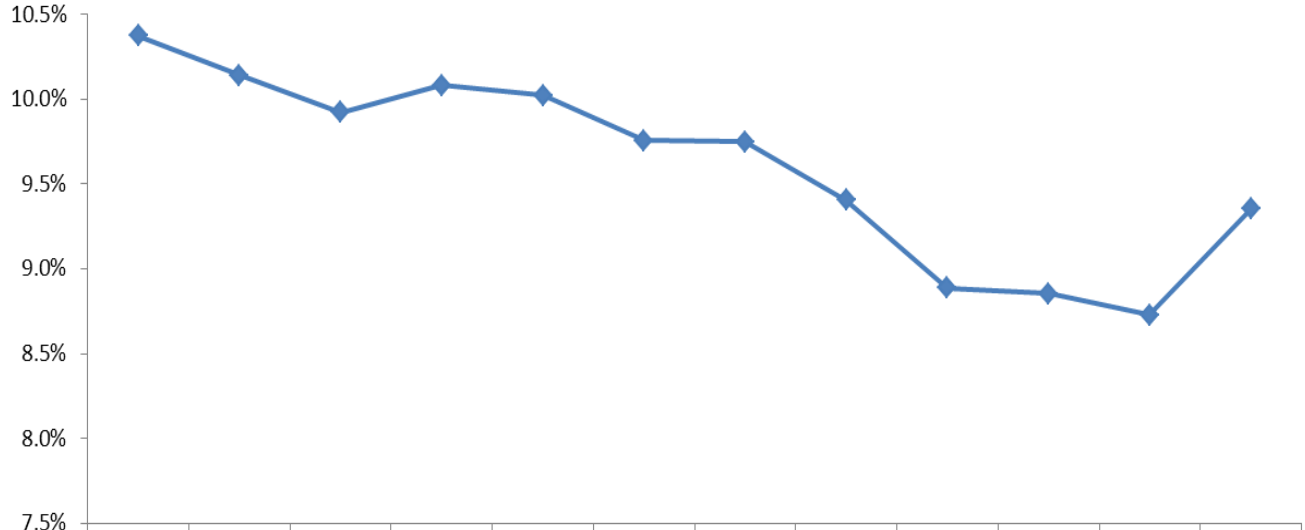
## Fixed Term Staff Starters (Headcount) by Staff Group




| | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Other | 1 | 1 | 6 | 2 | 4 | 1 | 30 | 18 | 8 | 1 | 6 | 8 |
| Administrative and Clerical | 6 | 9 | 1 | 3 | 3 | 2 | 1 | 0 | 4 | 3 | 2 | 4 |
| Medical and Dental | 19 | 8 | 6 | 7 | 11 | 5 | 3 | 16 | 7 | 1 | 63 | 12 |
| Nursing and Midwifery Registered | 3 | 3 | 10 | 12 | 0 | 10 | 0 | 1 | 1 | 1 | 1 | 0 |

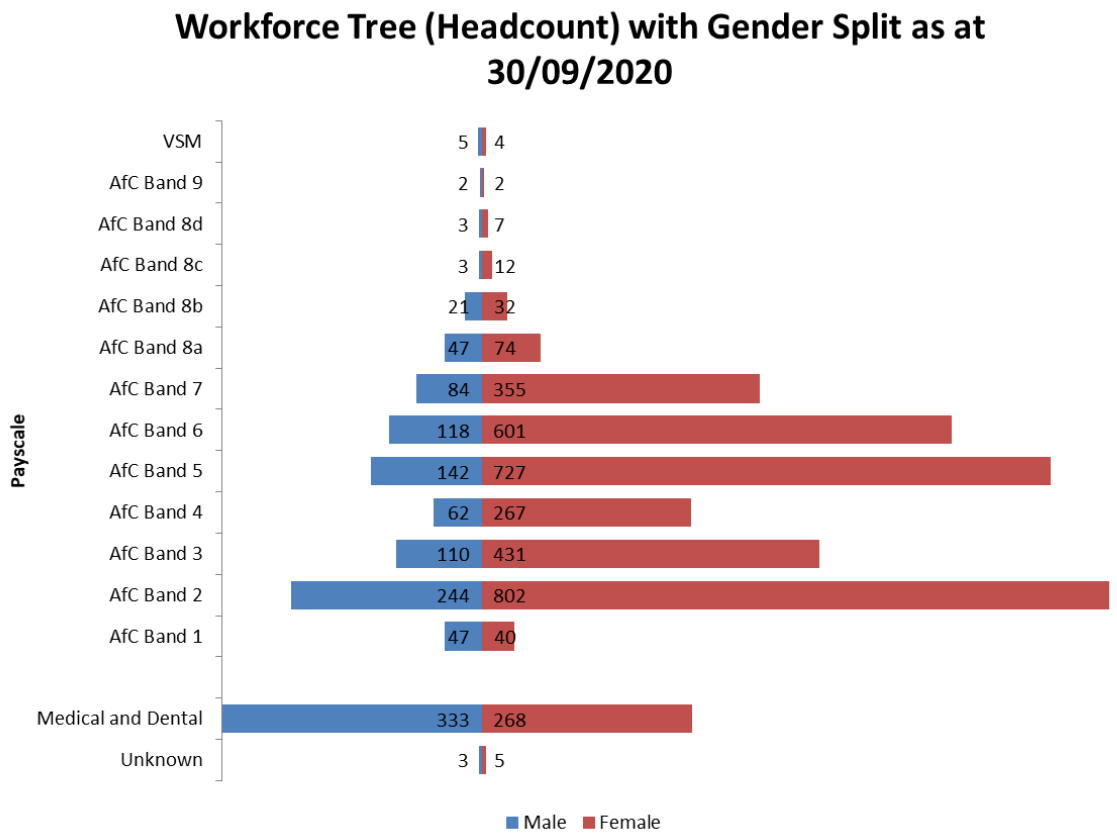
Turnover of staff has remained within 1% for the six months from 1 April 2020, although a slight decrease occurred between June and August. This may be as a result of Covid-19 and other organisations not recruiting as many staff as previously.

## Permanent Staff Turnover Rate (Headcount)




| | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 10.37% | 10.14% | 9.92% | 10.08% | 10.02% | 9.75% | 9.75% | 9.40% | 8.89% | 8.86% | 8.73% | 9.35% |

The overall gender split is 25%/75% male/female, with the gender split by band shown below.



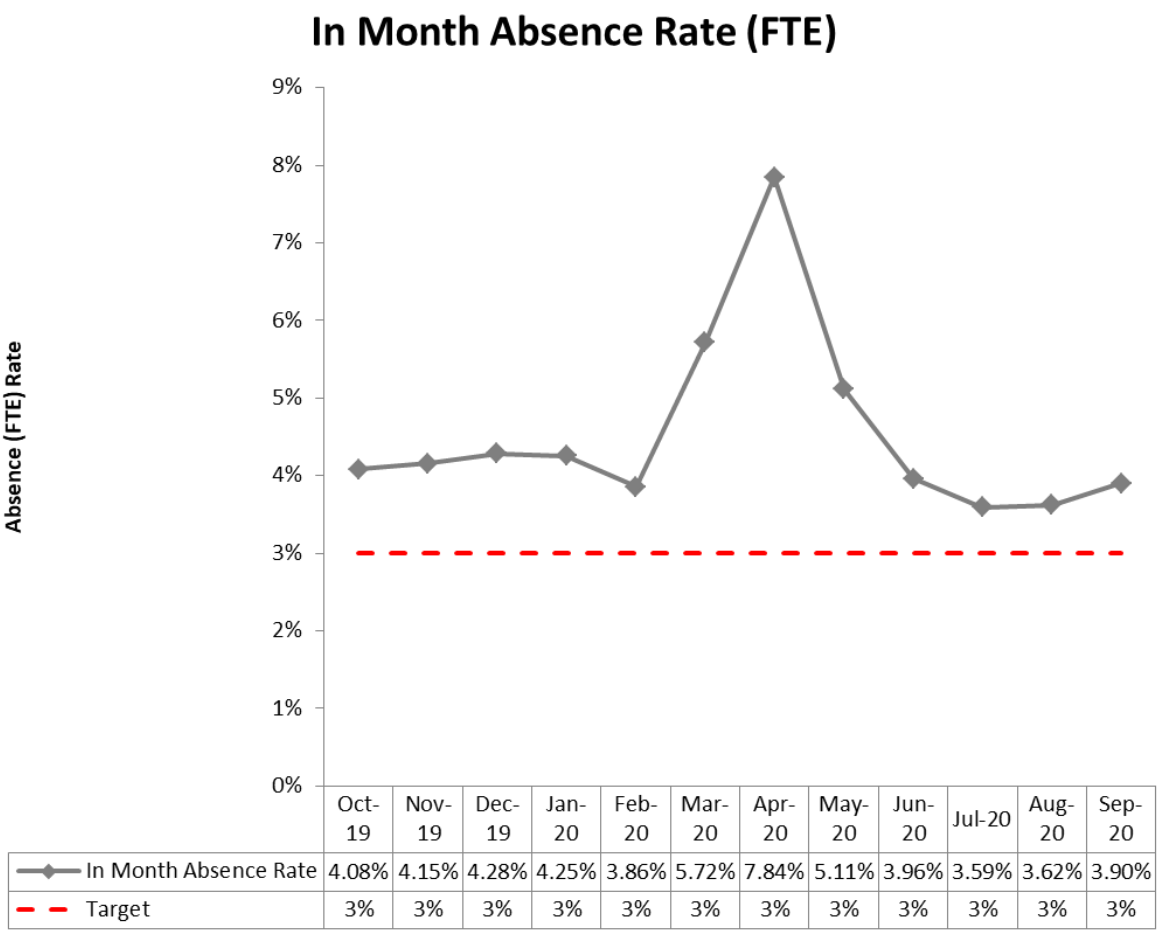

Information on gender pay gap can be found on the Cabinet Office website: Https://gender-pay.service.gov.uk

**Sickness absence data**

Sickness absence data for 2019/20 is published by NHS digital:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

In month for the Trust can be seen on the following page. The sharp spike between March and July can largely be attributed to Covid-19 absence.




| | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| In Month Absence Rate | 4.08% | 4.15% | 4.28% | 4.25% | 3.86% | 5.72% | 7.84% | 5.11% | 3.96% | 3.59% | 3.62% | 3.90% |
| Target | 3% | 3% | 3% | 3% | 3% | 3% | 3% | 3% | 3% | 3% | 3% | 3% |

**Information on Counter Fraud**

The Trust has an Anti-Fraud, Bribery and Corruption policy in place endorsed by senior management and the Trust's Audit Committee. The Human Resources department maintain strong links with the Counter Fraud team, who are invited to an investigators meeting twice a year. This period this was conducted for the first time using Microsoft Teams. This is a good way to exchange information, changes to process and learning from cases.

**Exit packages/Settlement agreements**

Within all large organisations there will be occasional disputes between staff. The Trust has in place a number of measures to prevent and address these when they happen, including a robust reporting system for bullying and harassment; facilitated meetings; mediation, performance management, disciplinary and grievance processes.

Occasionally it may not be possible to resolve employee relations issues and consideration may be given to negotiating a settlement agreement, particularly where a case may escalate to an Employment Tribunal. Often settlement is made on commercial grounds and does not necessarily indicate any fault with Trust processes. From April to September 2020 the Trust made the following settlements:

| Reason for settlement | Amount | Date |
|---|---|---|
| Contractual settlement | £2260 | September 2020 |

**Risk management**

Risk management and health and safety training is included on induction and mandatory training programmes for all staff with additional risk assessment, duty of candour and root cause analysis training sessions for clinical leads, heads of department and ward leaders.

**Staff policies**

Between April and September 2020 a joint Trust policy task and finish group, which included representatives from Human Resources and Staff Side, began to meet each week to review and up-date HR policies for the new organisation. The group initially concentrated on the most frequently used policies, Managing Attendance; Managing Disciplinary Issues; Managing Performance and Handling Grievances, which were subsequently sent to the UHD Staff Partnership Forum for ratification.

The group also considered all the HR policies across both Trusts and agreed which would be used on an interim basis for new starters at UHD, until all the policies have been revised.

**Disability Confident Scheme** (previously named the Guaranteed Interview Scheme (GIS) or Two ticks Scheme)

The Trust is an accredited Disability Confident employer, and candidates with a recognised disability meeting the minimum essential criteria for a role are offered an interview. This applies to both internally and externally advertised posts. The aim of this commitment is to encourage people with disabilities to apply for jobs by offering an assurance that should they meet the essential criteria in the person specification they will be given the opportunity to demonstrate their abilities at the interview stage.

Where candidates indicate that they wish to be interviewed under the scheme in their application on NHS Jobs, they must be included in the shortlist for interview, where they meet the essential criteria for the position.

The Trust has a process for making reasonable adjustments or if necessary a redeployment procedure, both of which can be used should an employee become disabled during employment with the Trust:

**Redeployment (Sickness Absence policy)**

If it is identified that an employee has to be redeployed due to ill-health, they will be formally placed on the redeployment register, following a redeployment meeting with their line manager who will explain the process to be followed.

**Disability (Sickness Absence policy)**

A disabled person in terms of the Equality Act (2010) is someone who has a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day to day activities.

## The Trade Union

The Trade Union (Facility Time Publication Requirements) Regulations 2019
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
**1 April to 30 September 2020**

**Relevant union officials**

What was the total number of your employees who were relevant union officials during the relevant period?

| *Number of employees who were relevant union officials during the relevant period* | *Full-time equivalent employee number* |
|---|---|
| 32 | 28.41 |

**Table 2**

**Percentage of time spent on facility time**

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

| *Percentage of time* | *Number of employees* |
|---|---|
| 0% | 23 |
| 1-50% | 8 |
| 51%-99% | 1 |
| 100% | 0 |

**Table 3**

**Percentage of pay bill spent on facility time**

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

| *First Column* | *Figures* |
|---|---|
| Provide the total cost of facility time | £11,636 |
| Provide the total pay bill | £115,188,013 |
| Provide the percentage of the total pay bill spent on facility time, calculated as:<br>(total cost of facility time ÷ total pay bill) x 100 | 0.01% |

**Table 4**

**Paid trade union activities**

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

| | |
|---|---|
| *Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:*<br>*(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100* | If TU activities have been paid, this will have been included in facility time calculations. |

## Staff Surveys

### Staff Engagement

Staff engagement is at the core of our organisational development plan. This period we have continued to work with our Inclusion Champions and Staff Network Group leads and allies. Our joint Cultural Champions have worked together to conduct a very successful review of what is important to us at work. They have made recommendations for the new UHD values and culture development for our new Trust.

### NHS National Staff Survey

The NHS staff survey is conducted annually. The fieldwork period for 2020, in which the survey is open for eligible staff to complete is from October to November 2020. The 2020 results will be published as two separate Trusts but they will combine data to inform the merged Trust.

The response rate to the 2019 survey amongst eligible Trust staff was 47.8% (2018: 52.8%). The results are grouped into 10 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being an average of those.

Scores for each indicator together with that of the survey benchmarking group (Acute Trusts) are presented below, comparing with the top score of similar acute Trusts:

| | 2019 | | 2018 | | 2017 | |
|---|---|---|---|---|---|---|
| | Trust | Benchmarking group (top score) | Trust | Benchmarking group (top score) | Trust | Benchmarking group (top score) |
| Equality, diversity and inclusion | 9.2 | 9.4 | 9.2 | 9.6 | 9.1 | 9.4 |
| Health and wellbeing | 6.4 | 6.7 | 6.4 | 6.7 | 6.4 | 6.6 |
| Immediate managers | 7.4 | 7.4 | 7.3 | 7.3 | 7.1 | 7.2 |
| Morale | 6.7 | 6.7 | 6.6 | 6.7 | N/A | N/A |
| Quality of appraisals | 6.1 | 6.6 | 6.1 | 6.5 | 6.0 | 6.4 |
| Quality of care | 7.8 | 8.1 | 7.7 | 8.1 | 7.8 | 7.9 |
| Safe environment – bullying and harassment | 8.3 | 8.5 | 8.4 | 8.5 | 8.3 | 8.4 |
| Safe environment – Violence | 9.4 | 9.6 | 9.5 | 9.6 | 9.5 | 9.6 |
| Safety culture | 7.2 | 7.2 | 7.2 | 7.2 | 6.9 | 7.1 |
| Staff Engagement | 7.5 | 7.5 | 7.5 | 7.6 | 7.4 | 7.4 |
| Teamworking | 7.2 | 7.2 | 7.1 | 7.1 | 7.0 | 7.0 |

Following our 2019 results, we were pleased to work closely with Poole Hospital to develop joint actions ahead of our planned merger.

## Future priorities and targets

In 2019 we identified that there was still work to be done on the theme Safe Environment – Violence, as this is the only theme that is not significantly better than our benchmarking group of Acute Trusts. The Trust acknowledges that the number of staff who reported violence at work from patients or other members of the public had significantly increased. Training of staff, including Dementia awareness and Breakaway, Police accreditation of portering staff and development of 24/7 Psych Liaison services have all been progressed.

We also needed to focus on the visibility of our leaders. The Trust did score significantly higher than the rest our benchmarking group of Acute Trusts on all four questions around senior managers. However, the percentage of staff who know who the senior managers are had fallen since 2018 to 86%.

However, with the response to the COVID-19 pandemic, most of the survey action planning was put on hold and formal action plans have not been monitored during this period, as the focus has been on immediate support for staff.

There has been a sustained focus on our Equality, Diversity and Inclusion agenda and actions related to WRES and WDES. (See the next section).

Close work with Poole Hospital NHS Foundation Trust on our wellbeing and staff engagement activities during the COVID-19 pandemic and in planning our 2020 Staff Survey was undertaken. This period there were additional questions related to the pandemic.

## Embracing equality, diversity and inclusion

From April to September 2020 we have continued to make progress with the diversity and inclusion agenda into the day-to-day work of RBCH. Our work has included preparing to merge with Poole Hospital NHS Foundation Trust to create the new University Hospitals Dorset organisation, aligning the work streams and programmes across all three hospital sites. A new strategy is being developed with updated objectives and action plans reflecting the work in the legacy organisations and continuing to build on the small green shoots of improvement we have seen in the lived experience of our people in our organisations.

Being an inclusive employer is key to ensuring that we have a workforce with the skills and knowledge to provide the best service possible to the people of Bournemouth, Poole, Christchurch and surrounding areas, delivering on our vision and values.

The Covid-19 pandemic created many challenges during this period. Reflexive and responsive actions were needed to enable us to respond to the global awareness on discrimination and Black Lives Matter social movement, the disproportionate impact of the virus on ethnic communities and those with an underlying health condition and disability.

We have continued to support our colleagues from the EU with the Settled Status application process and worked closely with our partners in the community, Dorset Race Equality Council, to raise awareness of the dates and deadlines and provide specialist advice and support where this was needed to our people and their families.

Our Reverse Mentoring programme commenced in 2020 despite the start of the pandemic. Our senior leaders have been mentored by junior staff. We have continued to support the programme, switching to virtual online workshops with our external provider.

## Inclusion Networks

Our staff inclusion networks have worked tirelessly during this period to support their colleagues. Their maturity as networks has flourished, with increased confidence to take the lead, to challenge, to speak up and enable the voice of those seldom heard to be taken to the highest level. The networks have clear aims and purpose and have access to self- development through the inclusion champion programme.

The network leads have worked collaboratively during the pandemic and beyond. Intersectionality is a key part of the networks aims, enabling greater understanding how aspects of a person's social and political identities combine to create different modes of discrimination and privilege.

Our network leads have developed working relationships with leaders across the organisation to deliver awareness and education sessions, giving expert advice on policies and processes and being consulted for guidance on risk assessments, recruitment practices and new ways of working remotely.

## Our equality objectives 2018-2020

| | | |
|---|---|---|
| Improve black, Asian and minority ethnic (BAME) employee experience | Reverse Mentoring programme<br>Leadership development (stepping up programme) | Improving equal opportunities and supporting applications to national programmes |
| Development inclusive leadership capability | Unconscious bias workshops<br>Leadership Master classes (inclusion, civility) | In-house workshop developed<br>External speakers, classes open to all staff |
| Improve communications and engagement | Published communications plan | Calendar of events including local/national campaigns and religious festivals<br>Campaigns to raise awareness, increase understanding and engagement of staff networks and encourage a more diverse workplace |
| Develop effective staff networks | • LGBTQ+<br>• International Doctors Support Initiative<br>• BAME<br>• European staff<br>• Pro-ability<br>• Armed Forces Network | Rainbow badge inclusion campaign.<br>Trans patient guidelines<br>Support for overseas Doctors<br>WRES action plan<br>European Settlement Scheme support programme<br>WDES action plan<br>Armed forces covenant signed |
| Improve use of all equality, diversity and inclusion data and compliance against national standards | • The Equality Act (2010)<br>• The NHS Constitution<br>• The Public Sector Equality Duty (PSED)<br>• The NHS Equality Delivery System (EDS2)<br>• The Workforce Race Equality Standard (WRES)<br>• The Workforce Disability Equality Standard (WDES) | Working in partnership with all our staff networks and patient representatives.<br>Action plans developed and owned by those directly impacted. |
| Develop patient co-production and engagement | Working in partnership with the patient experience lead and volunteers | Patient partners working as experts by experience to support service and policy redesign |

## Working with others

The Trust is a proud member of the following diversity and inclusion programmes:

Stonewall Diversity Champions programme: Britain's leading best practice forum for LGBT Equality Diversity and Inclusion.

NHS Employers Diversity and Inclusion Partners Programme: An important opportunity to work in partnership with other Trusts and health and social care organisations to further refine our equality, diversity and inclusion approach. We are privileged to have been asked to continue into the 2020/21 alumni programme.

Disability Confident: A scheme designed to recruit and retain disabled staff and people with health conditions for their skills and talent.

## In Summary

2020 will be remembered as the year the world woke up to the true picture of racism, discrimination and inequality in our society and workplaces. This is an opportunity to make real change for the better, to look forward to a new more inclusive and equal world for everyone.

Progress against our equality, diversity and inclusion objectives is positive and we have seen significant improvements in awareness and ownership of leading inclusively and acting as an authentic ally.

Our inclusion networks are the cornerstone of our ongoing equality, diversity and inclusion engagement with our people and are the experts by experience to provide advice and guidance in many aspects of our organisational processes.

Our new values, developed by staff and patients, will be incorporated into a new equality, diversity and inclusion strategy for 2021 with refreshed objectives and a new Equality, Diversity and Inclusion committee. To make sustained diversity and inclusion progress it is imperative we have the right level of leadership commitment and accountability at all levels, that everyone in the new organisation understands diversity and inclusion is "everybody's business".

We will continue to work with our staff, our patients and all stakeholders to ensure inclusion is at the heart of everything we do.

## NHS Foundation Trust Code of Governance

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors considers the Trust to be fully compliant with the principles of the NHS Foundation Trust Code of Governance as well as with the provisions of the Code in all respects, save as to paragraph B.2.3 where there are other arrangements in place. Details of compliance or an explanation are provided in this report.

**Debbie Fleming**, Joint Chief Executive, 28 April 2021

# Annual Governance Statement 2020

**Scope of responsibility**

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

**The purpose of the system of internal control**

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for the period 1 April 2020 – 30 September 2020 and up to the date of approval of the annual report and accounts.

**Capacity to handle risk**

In my role as Accounting Officer, I have ultimate responsibility for ensuring that effective management systems and controls appropriate for the achievement of the Trust's objectives are in place, ensuring efficient and economic use of resources. As Chief Executive I am also responsible for ensuring that the Trust meets all statutory responsibilities and the requirements of the NHS provider licence and its Care Quality Commission registration. The Director of Nursing and Midwifery is responsible for supervising the management of the services regulated by the Care Quality Commission.

The Medical Director and Director of Nursing and Midwifery have joint delegated responsibility for managing the strategic development and implementation of organisational risk management and clinical governance. However, the requirement to manage risk more effectively is a responsibility affecting all staff in every part of the Trust; from the control of finance, through all the disciplines supporting and delivering the environment of care, to the direct delivery of clinical care itself, risk management is everyone's responsibility from ward to board.

The Trust's risk management strategy clearly defines these responsibilities and provides guidance for the fulfilment of these roles. This is underpinned by developing and supporting a culture that encourages an open and honest recording of risks and organisation-wide learning where risks are continuously identified, assessed and minimised. As Chief Executive, I sponsor the role of the Freedom to Speak Up Guardian, reports regularly to the Audit Committee and the Board of Directors to provide assurance around the reporting, safety and learning culture within the Trust as well as identifying key themes.

The Trust identifies, prioritises and manages all aspects of risk through its integrated governance framework. The Board of Directors has agreed a risk appetite and risk management framework and has reviewed and identified the Trust's principal objectives and mitigating strategies for any risks to the delivery of those objectives. Risks to delivery of the Trust's strategic objectives are documented in the Board Assurance Framework (BAF). The BAF is reviewed 6 monthly by the Board of Directors and quarterly by the Audit Committee to ensure that it is comprehensive and that the Trust's internal controls and risk management systems are operating effectively. The Trust uses a single risk register system and a standard risk register process. Risk mitigation is achieved through a continuous cycle of the identification, assessment, control and review of risk which supports our open and honest reporting culture. The Freedom to Speak Up Guardian reports quarterly to the Audit Committee and the Board of Directors to provide assurance around the reporting, safety and learning culture within the Trust as well as identifying key themes. The Audit Committee is also responsible for approving the Trust's speaking up policy.

High risks (those with a risk rating of 12-25), including any changes to these, are reviewed by the Board of Directors and Healthcare Assurance Committee at each meeting, with an in-depth focus on individual risks on a cyclical basis led by the executive Director sponsor of the individual risks. The work of the Board of Directors and its committees is supported by a range of specialist committees including the Trust Management Board, the Quality and Risk Committee, which focuses on clinical quality and risk management, the Clinical Audit and Effectiveness Group and directorate clinical governance and risk management committees. The Board of Directors and its committees also consider independent sources of assurance to verify the accuracy and completeness of the risks identified and the controls in place to mitigate them such as internal and external audit, counter fraud, commissioned independent reviews, clinical audit, Model Hospital data, Care Quality Commission reports and other external and peer reviews.

Risk management and health and safety training is included on induction and mandatory training programmes for all staff with additional risk assessment, duty of candour and root cause analysis training sessions for clinical leads, heads of department and ward leaders.

Formal training is supported by a variety of other resources that seek to promote and facilitate individual, departmental, directorate and organisational discussion and learning. Recommendations and learning from complaints, audits, peer reviews and incidents are discussed locally at directorate clinical governance groups, senior nurses and ward sister meetings, medical Grand Round meetings and department and ward team briefings. Actions and learning points are also shared with regulators and other stakeholders across the local healthcare system through meetings with commissioners, clinical network groups and patient safety forums. We also seek to learn from other organisations at national level through attending conferences, networks and from investigations carried out by the Care Quality Commission and the Health Safety Investigation Branch.

## The risk and control framework

**Risk management strategy**

Healthcare commissioners and providers in Dorset have developed a Pan Dorset Risk Management Framework. This includes a standard matrix for measuring risk and determining the level of risk that can be accepted at the key management levels within the organisation. Detailed guidance and advice on assessing, quantifying and managing risk is contained within the Foundation Trust's risk management strategy and policy and associated risk matrix and risk assessment toolkit. As part of the strategy, care group and directorate leads are responsible for maintaining directorate risk registers and for bringing high risks to the attention of the Quality and Risk Committee and the Healthcare Assurance Committee. Each of the other committees of the Board of Directors reviews the high risks relevant to areas within its scope of responsibility and the executive Director leads for each risk report to the Healthcare Assurance Committee on these risks. The Healthcare Assurance Committee and other board committees bring important matters to the attention of the Board of Directors.

As part of its integrated governance approach, risk management is integrated into business planning, quality improvement and cost improvement planning processes, ensuring that objectives are set across the organisation with plans to manage risk in accordance with quality impact assessment and risk assessment procedures.

The Trust's risk appetite statement defines the Board of Directors' appetite for each risk identified in relation to the achievement of the Trust's strategic objectives each financial year. Risks throughout the organisation will be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust continuously monitors risk appetite and risk control systems in place and utilises the assurance framework process to monitor, develop, implement, demonstrate and promote continuous improvement and learning. The effectiveness of the assurance framework and its application has been reviewed by the Healthcare Assurance Committee and verified by the internal auditors and the Audit Committee.

The Board of Directors has reviewed the Trust's principal corporate and strategic objectives and identified mitigating strategies for any risks to the delivery of those objectives using the BAF process. The development of the BAF has involved consideration of all objectives (strategic, quality, financial,

corporate, business, clinical, human resources etc.) and all risks. In addition, a comprehensive review has taken place of the Trust's committee structure and its ability to provide the necessary assurance to the Board of Directors in support of the BAF. The framework is specifically linked to the Trust's strategic objectives and to the regulatory requirements of the independent regulator and the Care Quality Commission. Within the BAF, principal risks are identified and key risk controls put in place to provide necessary assurances on identified gaps in control systems and action plans to further reduce risk are mapped against identified objectives. The BAF is populated from the Trust's risk register with risk reduction being achieved through a continuous cycle of the identification, assessment, control and review of risk.

Risks may be entered on the Trust's risk register as a result of risk issues being raised or identified by employees, directorates, external or internal reviews, internal or external audits, incident investigations, complaints reviews and comments from public stakeholders and/or service developments. Risks may also be raised by the board or board committees or by specialist subcommittees of these. These include the Healthcare Assurance Committee, Finance and Performance Committee, Workforce Strategy and Development Committee, Infection Prevention and Control Committee, Medicines Governance Committee, Information Governance Committee, Emergency Preparedness Committee, Quality and Risk Committee and Health & Safety Committee. All risks entered onto the risk register are categorised according to the Trust risk management strategy using a standard risk matrix common to all healthcare providers and commissioners in Dorset. The risk rating value is a combination of likelihood and consequence. All risks are assigned a current risk score and a target risk score following implementation of action plans and mitigation. All action plans have a responsible lead and timeframe noted. All high and corporate level risks are also assigned an executive Director lead.

Links have been established with the risk management system to enable better triangulation of quality information from incident reports, complaints, claims and risks at every level of the organisation. Staff can raise issues and concerns in a range of ways including through Learning Event Reporting Notification (LERN) Patient Safety and Staff Safety Incident Form and with the Freedom to Speak up Guardian and Freedom to Speak Up ambassadors, Change Champions and with Staff Governors.

**Key risks**

High risks (risks with a risk rating score of 12-25) on the Trust's risk register are routinely reviewed by the Healthcare Assurance Committee, which meets every other month. The Healthcare Assurance Committee is chaired by a non-executive Director and membership includes representation from the Board of Directors and the Council of Governors. The Quality and Risk Committee also reviews all new clinical risks monthly ensuring escalation to the Healthcare Assurance Committee and Trust Management Board, as appropriate. The full BAF is reviewed at least every six months. An annual review of risk management processes is incorporated within the internal audit programme approved by the Audit Committee. The current high risks are reported to the Board of Directors at each meeting, identifying any changes to those risks alongside an in-depth review of those risks on a cyclical basis.

The most significant risk facing the NHS and the Trust currently and in the future is the impact of Covid-19. It is clearly recognised that the standard ways in which the NHS operates have significantly changed as we all try to manage the impact of Covid-19 on the country and on the National Health Service. Normal business has been disrupted and new clinical pathways, policies and procedures have been introduced during the pandemic. We continue to adapt these on a daily basis in line with national, professional and local guidance to ensure staff and patient safety and maintain high standards of patient care. The Trust has identified the impact of Covid-19 as the most significant risk on the Trust risk register. Risks such as the availability of essential equipment, medications, staffing and skill mix are identified as both current and future risks. In addition we recognise that the pandemic has had, and will continue to have, a significant impact on our staff and a differential risk for BAME staff. We have put in place a raft of measures to support staff well-being including emotional, physical and psychological support.

There is a risk that the impact of Covid-19 will provide significant challenges to key performance targets that will impact on our patients, such as cancer access times and referral to treatment targets. The Trust continues to work with partners in the Dorset integrated care system to address these risks as well as through its own quality improvement projects. This includes implementation of the Clinical

Services Review and the merger with Poole Hospital NHS Foundation Trust to ensure integration of clinical pathways and clinical and corporate services.

The merger was successfully completed on 1 October 2020, having completed all the appropriate governance stages. The focus was on a "safe and legal" merger, with further integration to follow, especially as the risks of Covid were the focus of attention. As such the merger process was robust, but proportionate. A robust process to track merger and integration benefits has been established for the new organisation, UHD.

**Corporate governance**

These risks have been notified to the Board of Directors and also to NHS Improvement and commissioners as part of annual planning and regular reporting processes. The Board of Directors considers statements relating to compliance with this condition of the NHS provider licence on an annual basis as part of a self-certification process and these are also highlighted to the Board of Directors in advance of this through regular performance reporting. Annual compliance with the principles of good corporate governance and more detailed provisions of the NHS Foundation Trust Code of Governance is reviewed as part of the required disclosure which appears in this annual report. These are also reflected in the governance framework for the Board of Directors and its committees to support ongoing compliance.

More generally, the Board of Directors conducts its own reviews of its governance structures including reviews of performance by its committees to ensure that information provided to the Board of Directors identifies the key performance risks and the risks to compliance with the Trust's provider licence and other local and national performance targets, including its own performance objectives. These include indicators and measures relating to quality, safety, performance, clinical outcomes, productivity, workforce, activity and finance. Appraisals of both non-executive Directors and executive Directors take place annually with objectives and development plans identified, some of which are incorporated into the broader board development programme. This is supported by the work of the internal auditors.

**Workforce risks**

The reporting period (1 April 2020 – 30 September 2020) was a period of unprecedented challenge for the hospital workforce, facing the stark risks and realities of Covid-19 at the same time as driving towards the realisation of the long anticipated merger.

In this period the Trust ensured that risk mitigation decisions were taken in the context of fairness and consistency across both Trusts with policy and practice becoming even further aligned. There were significant challenges of supporting the RBCH workforce to stay safe and well, to do their essential work through Covid-19, and at the same time as progressing with due diligence and post-transaction implementation planning. Human Resources, Organisational Development, Occupational Health and Training resources were stretched throughout this period in supporting staff and managers (e.g. Q&As, Helplines, re-training, psychological support, daily communications) to mitigate Covid-19 related risks, to help maintain services and to deal with issues.

Throughout the Covid-19 pandemic the Trust benefitted from very regular and structured meetings to anticipate risks, progress action plans and to address issues as they presented. This became a daily challenge in periods of extreme operational pressure and where government policy presented new workforce information and requirements.

The Interim University Hospitals Dorset People Plan and emerging Organisational Development Plan together provided a high level vision and framework for the transition of the workforce. Alignment to the NHS People Plan ensured that plans were comprehensive and challenging in addressing risks and issues in both a local and national context. In a period of merger, these plans also started to address the Trust's cultural development programme so that staff could contribute to the future of University Hospitals Dorset. There was also an increasing emphasis on equality, diversity and inclusion networks and plans, prioritising Black Asian and Minority Ethnic staff experience and senior representation.

The Workforce Committee and Trust Board continued to review, monitor and where appropriate, challenge performance and risks in relation to lagging and leading workforce metrics (vacancies, new role requirements, overtime, absence, sickness, use of bank and agency).

The programme of work to achieve the optimal post-merger leadership structure under the joint Board to support the newly agreed University Hospitals Dorset Care Group configuration progressed well with Tier 2 (roles reporting into the Chief officers) starting to be appointed and with some progress in the corporate structures.

As merger approached, risks associated with known differences in policy and terms and conditions were managed effectively in line with the Transfer of Undertakings Protection of Employment Regulations (TUPE) and with the support of key stakeholders. Work progressed with Staff Side to consult around the TUPE process as we worked together to support the workforce up to merger.

With the Trusts working more closely this produced more benefits with a joined up workforce and access to a broader skill mix and greater scope in terms of workforce planning opportunities going forward, helping to address risks and issues and to ensure consistent practice and safe and high quality patient care. There were also early indications of a stronger position from which to progress sustainable workforce models in relation to the on-going implementation of the Clinical Services Review. Planning progressed towards realising the benefits of consistent application of technology with enabling workforce systems, improved rostering and flexible working practices.

The Medical Workforce Transformation Steering Group and Premium Cost Avoidance Group were essential in driving performance against medical and nursing workforce metrics with reviews focused on financial and quality targets. Bank and agency usage continued to be under particular scrutiny as plans progressed for further alignment of the staffing banks and where possible, consistent practice across the sites.

The Trust continued to participate in system-wide workforce discussions such as the Dorset Workforce Action Board (DWAB) - attended by senior executives across a range of health and social care organisations with key workforce issues raised and discussed. In this period there was an emphasis on joint Covid 19 planning and working cross-Dorset in order to optimise resources and synergies to address risks and issues. National shortages of key medical, clinical and allied health professionals also continued to be a priority for cross Dorset initiatives.

Allied health professional and healthcare scientist staffing was monitored and reviewed through the Care Group structures. In addition the AHP and HCS forum provided a structure for professional support.

Compliance with national quality and staffing safeguards was achieved through a variety of evidence based tools and techniques that support safe staffing decision making. On a daily basis, staffing meeting reviews ward staffing levels against patient acuity data, through a triangulated review of the electronic roster, Safe Care acuity tool and professional judgement.

Care quality outcomes linked to safe staffing were monitored and reviewed at all levels of the organisation using the Quality Dashboard, with direct links between quality matrices and staffing being made; this was evidenced through Directorate, Care Group and Trust meeting minutes. The Trust utilised a documented internal red flag system that set out clear parameters for safe staffing, enabling teams to raise concerns should their staffing fall below expectations. Any areas of significant concern relating to safe staffing were highlighted on the relevant risk register.

Nursing establishment skill mix reviews were undertaken bi-annually by the senior nursing team with review and reconciliation of acuity, outcomes and staffing requirements. Following each of these a report outlining the recommendations was prepared and taken to the Workforce Committee and Board of Directors in line with CQC and NHSE/I guidance.

All service changes that were permanent, including skill mix changes had a Quality Impact Assessment review undertaken, and Covid-related changes were assessed and reviewed through the Tactical Management governance.

**Information governance**

In line with NHS England/Improvement's guidance, risks to data security are managed and controlled through the Information Governance management structures and responsibilities established by the Trust's Information Governance Strategy and a range of the policies and procedures relating to Information Governance. These form part of the Trust's integrated governance approach to the management and monitoring of corporate and clinical governance, risk management and clinical effectiveness.

NHS Digital's Data Security and Protection (DSP) Toolkit is used to assess how well the Trust complies with the relevant legal and regulatory requirements and guidance relating to information governance. The DSP Toolkit sets the standard for cyber and data security for healthcare organisations, and places a much greater focus on assuring against modern threats. Based around the National Data Guardian's 10 Data Security Standards, the DSP Toolkit is divided into three categories of leadership obligations: People, Process and Technology. The DSP Toolkit places less emphasis on the provision of documentary evidence than previous assessments, and instead sets out the standards that organisations are required to meet with an expectation that this will be an ongoing journey towards compliance.

Owing to the Covid-19 pandemic, NHS Digital permitted organisations a six month extension to achieve compliance with the 2019/20 DSP Toolkit by 30 September 2020. The Trust was able to meet the requirements prior to that date, and submit a compliant DSP Toolkit in early September. The overall score for 2019/20 was 99% on mandatory requirements, and was graded as "Standards Met". As a consequence, the DSP Toolkit for 2020/21 was also delayed, and is due for release at the end of the calendar year.

From 1 April 2020 to 30 September 2020, one reportable IG breach occurred. This involved a set of historic patient notes from the Early Pregnancy Unit being found in a filing cabinet which had been sold to a member of the public. The member of the public who found these notes returned them to the patient to whom they related, who made a formal complaint to the Trust. The Trust reported the breach to the Information Commissioner's Office (ICO), as required. Following an investigation the ICO confirmed that no action was required against the Trust.

**Other regulation**

The Trust is fully compliant with the registration requirements of the Care Quality Commission. In the report published in June 2018, the Trust received an overall rating of 'Good' and 'Outstanding' for its leadership and use of resources. The Trust has not been reassessed during the period 1 April 2020 – 30 September 2020.

The Foundation Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

**Review of economy, efficiency and effectiveness of the use of resources**

As Accounting Officer I have responsibility to the Board for the economy, efficiency and effectiveness of the use of resources. This is achieved operationally through good governance systems of internal control designed to ensure that resources are applied efficiently and effectively;

The Trust employs a number of internal mechanisms and external agencies to ensure the best use of resources. This includes reviewing Model Hospital data provided by NHS Improvement to improve productivity and efficiency and the Care Quality Commission Insight report. The Trust received its first use of resources assessment in 2018 as part of the CQC well-led rating, where it received a rating of 'Outstanding'.

The Trust also includes the use of quality impact assessments as part of its cost improvement programme, drawing a link between quality improvement and achieving greater efficiency. Executive and senior managers in the organisation have responsibility for the effective management and deployment of their staff and other resources to maximise the efficiency of their directorates or departments. This is monitored in detail by the Finance and Performance Committee of the Board of Directors and the Board of Directors.

During the period ending 30 September 2020, national interim financial arrangements were in place in response to the COVID-19 pandemic. Consistent with this interim approach, each NHS organisation within the Dorset ICS achieved its individual break-even control total, supporting the achievement of the aggregate system control total.

In terms of longer term financial planning, the Trust continues to work in partnership with other Trusts in Dorset and commissioners as part of the Clinical Services Review and the ICS for Dorset, which also includes the local authorities.

**Data quality and governance**

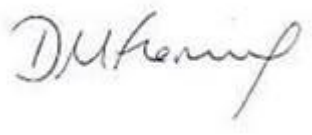
The Directors have not been required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Account for the financial year 2019/2020 or for the period 1 April 2020 – 30 September 2020. However in keeping with previous years an annual Quality Report 2019/20 was produced and presented to the Board of Directors for approval. The production of the Annual Quality Report was overseen by the Director of Nursing and Midwifery and co-ordinated by the Associate Director of Quality and Risk. This team leads on all regulatory quality assessments for the Trust and is experienced in this type of work. To ensure a balanced approach and data accuracy, input to the report was obtained from a wide range of sources within the organisation through the Trust governance infrastructure.

The production processes have mirrored those used for all quality assessments and aspects of these have been regularly checked and validated as part of routine governance processes. Data management largely handled by the Trust's Information Department, Risk Management Department and the Clinical Audit Department, all of which are subject to internal and external quality checking and control.

**Review of effectiveness**

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

**Conclusion**
Based upon available Department of Health guidance, and the Trust's internal and external auditor's views, the Board of Directors has not identified any significant internal control issues at this time.



**Debbie Fleming**
Joint Chief Executive
28 April 2021

# Consolidated financial statements

For the six months ended
30 September 2020

# Contents

# The Foundation Trust

| | | |
|---|---|---|
| **NHS Foundation Trust Code:** | **RDZ** | |
| **Registered Office:** | **The Royal Bournemouth Hospital**<br>Castle Lane East<br>Bournemouth<br>BH7 7DW | |
| **Executive Directors:** | **Mrs D Fleming** | Interim Joint Chief Executive |
| | **Mrs P Shobbrook** | Director of Nursing and Midwifery |
| | **Mr P Papworth** | Interim Joint Director of Finance |
| | **Mr R Renaut** | Chief Operating Officer |
| | **Mrs K Allman** | Director of Human Resources |
| | **Dr A O'Donnell** | Medical Director |
| | **Mr P Gill** | Director of Informatics |
| **Non-Executive Directors:** | **Mr D Moss** | Interim Joint Chairperson |
| | **Ms C Hallett** | Non-Executive Director |
| | **Mr A Jablonowski** | Non-Executive Director |
| | **Mr J Lelliott OBE** | Non-Executive Director |
| | **Mr DI Rawlinson** | Non-Executive Director |
| | **Mr C Shearman** | Non-Executive Director |
| | **Mr P Davé** | Non-Executive Director |
| **Trust Secretary:** | **Ms J Hall** | |
| **Banker:** | **Barclays PLC**<br>London | |
| **Solicitor:** | **DAC Beachcroft LLP**<br>Winchester | |
| **Internal Auditor:** | **BDO LLP**<br>Southampton | |
| **External Auditor:** | **KPMG**<br>Southampton | |

# Foreword to the accounts

These accounts for the six months ended 30 September 2020 for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the "Foundation Trust") have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

**Mrs D Fleming**
Interim Chief Executive
28 April 2021

# Accounting Officer's Statement

**Statement of the Chief Executive's responsibilities as the Accounting Officer of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.**

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust to prepare for each financial period a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial period.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

**Mrs D Fleming**
Interim Chief Executive
28 April 2021

# Independent auditor's report

## to the Council of Governors of University Hospitals Dorset NHS Foundation Trust, on behalf of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

### REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

#### 1. Our opinion is unmodified

We have audited the financial statements of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust ("the Trust") for the period ended 30 September 2020 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements of Cash Flows, and the 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 Group's and the Trust's affairs as at 30 September 2020 and of the Group's and Trust's income and expenditure for the period then ended; and

— the Group's and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

| Overview | |
|---|---|
| **Materiality:** Group financial statements as a whole | £3.4m (2019-20: £6.4m)<br>2% (2019/20: 2%) of total operating income |
| **Coverage** | 99.6% (2019/20: 99.7%) of total operating income |

| **Risks of material misstatement** | **vs** | **20219/20** |
|---|---|---|
| **Recurring risks** | Valuation of land and buildings | ▲ |
| | Recognition of NHS and non-NHS Income | ◄► |
| | Recognition of Non-Pay Expenditure | ◄► |

| **Key** | |
|---|---|
| ◄► | Risk level unchanged from prior year |
| ▲ | Increased risk in the period |

#### Basis for opinion

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 Group and Trust 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.

#### Emphasis of matter- going concern basis of preparation

We draw attention to the disclosure made in note 1 to the financial statements which explains that whilst the trust was dissolved on 1 October 2020 as part of the merger with Poole Hospital NHS Foundation Trust, the financial statements of the Trust have been prepared on a going concern basis because its services are continuing to be provided by the successor foundation trust (University Hospitals Dorset NHS Foundation Trust).

Our opinion is not modified in respect of this matter.

## 2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below the key audit matters (unchanged from 2019-20 in decreasing order of audit significance, in arriving at our audit opinion above, together with our key audit procedures to address those matters and our findings ("our results") from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed , and our results are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon , and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters. All of these key audit matters relate to the Group and the parent Trust.

| | The risk | Our response |
|---|---|---|
| **Land and Buildings**<br><br>*(£151.4m ; 2019/20: £155.1m )*<br><br>*Refer to page 23 (Audit Committee Report), note 1 of the financial statements (accounting policies) and note 8 of the financial statement (financial disclosures)* | **Subjective valuation**<br><br>Land and buildings are required to be held at current value in existing use. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'. 98.5% of the Group's land and buildings are deemed specialised as at 30 September 2020.<br><br>When considering the cost to build a replacement asset the Trust may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic.<br><br>A valuation is completed by an external expert, engaged by the Trust using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with interim desktop valuations completed in interim periods.<br><br>The Trust had a full valuation undertaken by an external valuer as at 31 March 2020 and a desktop revaluation as at 30 September 2020.<br><br>Valuations are inherently judgemental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, were appropriate and correctly applied.<br><br>The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole. | Our procedures included:<br><br>— **Assessing valuer's credentials:** We considered the scope, qualifications and experience of the valuer, to identify whether the valuer was appropriately experienced and qualified to provide relevant indices;Test of details: We undertook the following tests of details:<br><br>— **Methodology choice:** We considered the overall methodology of the external valuation performed to identify whether the approach was in line with industry practice, assisted by our Estate Valuation specialist;<br><br>— **Benchmarking assumptions:** We critically assessed the assumptions used within the valuation by assessing the assumptions used to derive the carrying value of assets against BCIS all in tender price index and industry norms and utilising our Estate Valuation specialist;<br><br>— **Test of details:** We undertook the following tests of details:<br><br>– We tested the completeness of the estate covered by the valuation to the Trust's underlying estate records, including additions to land and buildings during the period;<br><br>– We re-performed the calculation of gain or loss on revaluation for all applicable assets and checked whether the accounting entries were consistent with the DHSC Group Accounting Manual; and<br><br>— For a sample of assets added during the period we agreed that an appropriate valuation basis had been adopted when they became operational and that the Trust would receive future benefits.<br><br>— **Assessing transparency:** We assessed the completeness and accuracy of the matters covered in the valuations disclosure, including the group's disclosures of the sensitivity of the valuation.<br><br>— **Our results:** From the evidence obtained, we considered the valuation of land and buildings and related disclosure to be acceptable. |

| | The risk | Our response |
|---|---|---|
| **Recognition of NHS and non-NHS income**<br>*(£173.9m ; 2019/20: £334.8m )*<br>*Refer to page 23 (Audit and Governance Committee Report), note 1 of the financial statements (accounting policies) and note 2 of the financial statement (financial disclosures)* | **Effects of Irregularities**<br>Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk.<br>We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial targets.<br>We have classified NHS and non-NHS income as a significant risk to respond to this requirement. | Our procedures included:<br>**Control observations:**<br>We tested the design and operation of process level controls over revenue recognition;<br>**Test of details:**<br>As a result of Covid-19 there were changes to the funding arrangements for the 2020-21 financial year. For April to September 2020 NHS providers were provided with additional funding to deliver a 'break even' position.<br>We undertook the following tests of details:<br>– We agreed £139.5m of commissioner income back to contracts and bank receipts;<br>– We agreed £10.8m of Covid-19 top up funding to bank receipts.<br>– We tested a samples of £21.55m of remaining income to invoices and bank receipts.<br>– £2m relates to notional income adjusted for the PPE stock recognized as a subsequent event.<br>**Our results**<br>– The results of our testing were satisfactory and we considered the amount of NHS and non-NHS income recognised to be acceptable |

| | The risk | Our response |
|---|---|---|
| **Recognition of non-pay expenditure**<br>*(£55.1m ; 2019/20: £118m )*<br>*Refer to page 23 (Audit and Governance Committee Report), note 1 of the financial statements (accounting policies) and note 3 of the financial statement (financial disclosures)* | **Effects of Irregularities:**<br>As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures.<br>The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of recognition of non-pay expenditure at the period-end.<br>There may therefore be an incentive to defer non-pay expenditure or recognise commitments at a reduced value in order to achieve financial targets. | Our procedures included:<br>**Control observations:** We tested the design and operation of process level controls over expenditure approval;<br>**Test of details:** We undertook the following tests of details:<br>— We agreed a specific item sample of non pay expenditure transactions to supporting evidence and cash;<br>— We inspected invoices for material expenditure in the month prior to 30 September 2020 to determine whether expenditure was recognised in the correct accounting period relevant to when services were delivered;<br>— We assessed the completeness and judgements made within the expenditure balance, specifically accrued expenditure, through comparison to historical performance.<br>**Our results:**<br>— The results of our testing were satisfactory and we considered the amount of non-pay expenditure recognised to be acceptable. |

## 3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £3.4 million (2019-20: £6.4 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%) (2019-20: 1.9%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

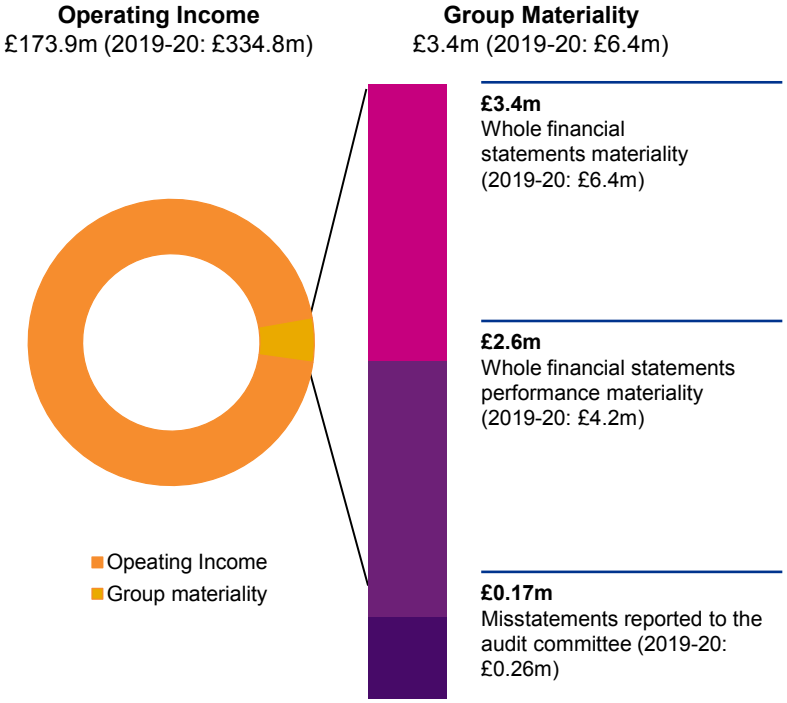
Materiality for the parent Trust's financial statements as a whole was set at £3.4 million (2019-20: £6.3 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%) (2019-20: 1.9%).

In line with our audit methodology, our procedures on individual account balances and disclosures were performed to a lower threshold, performance materiality, so as to reduce to an acceptable level the risk that individually immaterial misstatements in individual account balances add up to a material amount across the financial statements as a whole.

Performance materiality was set at 75% (2019-20: 75%) of materiality for the financial statements as a whole, which equates to £2.6 million (2019-20: £4.8 million) for the group and £ 2.6 (2019-20: £4.8 million) for the parent Trust We applied this percentage in our determination of performance materiality because we did not identify any factors indicating an elevated level of risk.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.17 million (2019-20:(£0.26 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Of the group's 1 (2019-20: 3) reporting components, we subjected 1 (2019-20: 1) to full scope audits for group purposes. We conducted reviews of financial information (including enquiry) at a further 2 (2019-20: 2] non-significant components.




## 4. Fraud and breaches of laws and regulations – ability to detect

*Identifying and responding to risks of material misstatement due to fraud*

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to the Group's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve control totals delegated to the Group by NHS Improvement
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Group's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk that additional funding was claimed inappropriately through the extra resources made available as a result of Covid-19 and the risk that Group and component management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 'Audit of Financial Statements of Public Sector Bodies in the United Kingdom' we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals and provisions.

We did not identify any additional fraud risks.

In determining the audit procedures we took into account the results of our evaluation and testing of the operating effectiveness of some of the Group-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unbalanced journals and journal entries made to unrelated accounts.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Ensuring the completeness of transactions during the period by performing the closing trial balance reconciliation/ mapping.

*Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations*

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and management (as required by auditing standards), and discussed with the directors and management the policies and procedures regarding compliance with laws and regulations.

As the Group is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Group is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Group is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

*Context of the ability of the audit to detect fraud or breaches of law or regulation*

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

## 6. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. 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. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

*Annual Governance Statement*

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020-21. We have nothing to report in this respect.

*Remuneration and Staff Reports*

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020-21.

## 7. Respective responsibilities

*Accounting Officer's responsibilities*

As explained more fully in the statement set out on page 5, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also 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; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of their services to another public sector entity.

*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

## REPORT ON OTHER LEGAL AND REGULATORY MATTERS

### Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The financial statements of the Group and Trust are for the six month period ended 30 September 2020 and therefore, in line with the Code of Audit Practice, we are not required to report on the Group and Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources.

### We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

## THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

## CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for the six month period ended 30 September 2020 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

**Jonathan Brown**
**for and on behalf of KPMG LLP (Statutory Auditor)**

*Chartered Accountants*
*66 Queen Square,*
*Bristol, BS1 4BE*
*28th April 2021*

KPMG

# Statement of Financial Position

| | | Group | | Trust | |
|---|---|---|---|---|---|
| | Notes | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | | **£'000** | £'000 | **£'000** | £'000 |
| **Non-current assets** | | | | | |
| Intangible assets | 14 | **13,848** | 12,260 | **13,848** | 12,260 |
| Property, plant and equipment | 14 | **179,368** | 180,663 | **179,363** | 180,657 |
| Investments in LLP Joint Venture | 12.1 | **1,815** | 1,907 | **1,815** | 1,907 |
| Other Investments | 12.2 | **4,544** | 3,990 | **-** | - |
| Trade and other receivables | 18 | **746** | 746 | **746** | 746 |
| **Total non-current assets** | | **200,321** | 199,566 | **195,772** | 195,570 |
| **Current assets** | | | | | |
| Inventories | 17 | **4,410** | 4,816 | **4,410** | 4,816 |
| Trade and other receivables | 18 | **11,297** | 19,115 | **11,566** | 19,065 |
| Other financial assets | | **47** | 47 | **-** | - |
| Cash and cash equivalents | 19 | **88,559** | 60,538 | **85,439** | 57,753 |
| **Total current assets** | | **104,313** | 84,516 | **101,415** | 81,634 |
| **Current liabilities** | | | | | |
| Trade and other payables | 20 | **(40,784)** | (42,356) | **(38,782)** | (40,433) |
| Borrowings | 22 | **(1,281)** | (1,370) | **(1,281)** | (1,370) |
| Provisions | 24 | **(761)** | (385) | **(761)** | (385) |
| Other liabilities | 21 | **(29,269)** | (4,879) | **(29,269)** | (4,879) |
| **Total current liabilities** | | **(72,094)** | (48,990) | **(70,093)** | (47,067) |
| **Total assets less current liabilities** | | **232,540** | 235,092 | **227,094** | 230,137 |
| **Non-current liabilities** | | | | | |
| Borrowings | 22 | **(13,922)** | (14,540) | **(13,922)** | (14,540) |
| Provisions | 24 | **(2,040)** | (2,042) | **(2,040)** | (2,042) |
| Other liabilities | 21 | **(869)** | (885) | **(869)** | (885) |
| **Total non-current liabilities** | | **(16,831)** | (17,467) | **(16,831)** | (17,467) |
| **Total assets employed:** | | **215,709** | 217,625 | **210,263** | 212,670 |
| **Taxpayers' equity** | | | | | |
| Public Dividend Capital | | **85,466** | 85,184 | **85,466** | 85,184 |
| Revaluation reserve | | **66,216** | 67,895 | **66,216** | 67,895 |
| BHT Charitable Fund Reserve | | **1,541** | 1,541 | **-** | - |
| Income and expenditure reserve | | **58,581** | 59,591 | **58,581** | 59,591 |
| NHS Charitable Fund Reserve | 34 | **3,906** | 3,414 | **-** | - |
| **Total Taxpayers' equity:** | | **215,710** | 217,625 | **210,263** | 212,670 |

The notes on pages 18 to 58 form part of these accounts.

The financial statements comprising the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, and Statement of Cash Flows were approved by the Foundation Trust Board on 28 April 2021 and signed on its behalf by:

**Mrs D Fleming,** Interim Joint Chief Executive, 28 April 2021

# Statement of Comprehensive Income

| | | Group | | Trust | |
|---|---|---|---|---|---|
| | Notes | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | | **£'000** | £'000 | **£'000** | £'000 |
| Operating income from continuing operations | 4 | **173,893** | 334,847 | **173,269** | 333,881 |
| Operating expenses of continuing operations | 7 | **(173,062)** | (335,906) | **(172,375)** | (335,046) |
| **OPERATING (DEFICIT) / SURPLUS** | | **831** | (1,059) | **894** | (1,165) |
| **FINANCE COSTS** | | | | | |
| Finance income: interest receivable | 12 | **1** | 404 | **-** | 398 |
| Finance expense: interest payable | 13 | **(250)** | (480) | **(250)** | (480) |
| Finance expense: Unwinding of discount on provisions | 24 | **(0)** | 1 | **(0)** | 1 |
| Public Dividend Capital: Dividends payable | | **(1,959)** | (4,641) | **(1,959)** | (4,641) |
| Movement in fair value of investment property and other investments | | **553** | (214) | **-** | - |
| (Loss) Profit from Joint Venture | | **305** | 3,767 | **305** | 3,767 |
| **(DEFICIT) FOR THE PERIOD** | | **(518)** | (2,222) | **(1,010)** | (2,120) |
| **Other comprehensive income** | | | | | |
| Impairment (chargeable to revaluation reserve) | | **(1,987)** | (6,207) | **(1,987)** | (6,207) |
| Revaluation (credited to revaluation reserve) | | **308** | 1,727 | **308** | 1,727 |
| **TOTAL COMPREHENSIVE (EXPENSE) FOR THE PERIOD** | | **(2,197)** | (6,702) | **(2,689)** | (6,600) |

The notes on pages 18 to 58 form part of these accounts.

# Statement of Changes in Taxpayers' Equity

| | Trust | | | | BHT Charity | RBCH Charity | Group |
|---|---|---|---|---|---|---|---|
| | Public Dividend Capital | Revaluation Reserve | Income and Expenditure Reserve | Trust Reserves | Other Reserves | Charitable Fund Reserve | Total Reserves |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Current Period** | | | | | | | |
| **Taxpayers' Equity at 1 April 2020** | **85,184** | **67,895** | **59,591** | **212,670** | **1,541** | **3,414** | **217,625** |
| | | | | | | | |
| Surplus/(deficit) for the period | - | - | (1,010) | (1,010) | 0 | 492 | **(518)** |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve | - | - | - | - | - | - | **-** |
| Impairment losses on property, plant and equipment | - | (1,987) | - | (1,987) | - | - | **(1,987)** |
| Revaluations of property, plant and equipment | - | 308 | - | 308 | - | - | **308** |
| Public Dividend Capital received | 282 | - | - | 282 | - | - | **282** |
| **Taxpayers' Equity at 30 September 2020** | **85,466** | **66,216** | **58,581** | **210,263** | **1,541** | **3,906** | **215,710** |
| | | | | | | | |
| **Prior Period** | | | | | | | |
| **Taxpayers' Equity at 1 April 2019** | **80,691** | **73,266** | **60,820** | **214,777** | **1,700** | **3,557** | **219,834** |
| | | | | | | | |
| Surplus/(deficit) for the period | - | - | (2,120) | (2,120) | (160) | 57 | **(2,223)** |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve | - | (891) | 891 | - | - | - | **-** |
| Impairment losses on property, plant and equipment | - | (6,207) | - | (6,207) | - | - | **(6,207)** |
| Revaluations on property ,plant and equipment | - | 1,727 | - | 1,727 | - | - | **1,727** |
| Public Dividend Capital received | 4,493 | - | - | 4,493 | - | - | **4,493** |
| **Taxpayers' Equity at 31 March 2020** | **85,184** | **67,895** | **59,591** | **212,670** | **1,541** | **3,414** | **217,625** |

The notes on pages 18 to 58 form part of these accounts.

# Statement of Cash Flows

| | Notes | Group | | | | Trust | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | **30 September 2020** | | 31 March 2020 | | **30 September 2020** | | 31 March 2020 | |
| | | **£'000** | | £'000 | | **£'000** | | £'000 | |
| **Cash flows from operating activities** | | | | | | | | | |
| Operating surplus from continuing operations | | | **831** | | (1,059) | | **894** | | (1,165) |
| Operating surplus of discontinued operations | | | **-** | | - | | **-** | | - |
| Operating surplus/(Deficit) | | | **831** | | (1,059) | | **894** | | (1,165) |
| | | | | | | | | | |
| **Non-cash income and expense** | | | | | | | | | |
| Depreciation and amortisation | 14 | **4,661** | | 8,983 | | **4,661** | | 8,810 | |
| Impairments / Reversal of Impairments | 14 | **651** | | 3,193 | | **651** | | 3,193 | |
| Non-cash donations/grants credited to income | | **(0)** | | - | | **(0)** | | (1,167) | |
| (Increase)/Decrease in Trade and Other Receivables | | **7,503** | | 26,193 | | **7,469** | | 26,395 | |
| (Increase)/Decrease in Inventories | | **406** | | 258 | | **406** | | 258 | |
| Increase/(Decrease) in Trade and Other Payables | | **(4,007)** | | 664 | | **(3,926)** | | 771 | |
| Increase/(Decrease) in Other Liabilities | | **24,374** | | 1,917 | | **24,374** | | 1,917 | |
| (Increase)/Decrease in provisions | | **373** | | 576 | | **373** | | 576 | |
| NHS Charitable Fund - net adjustments for working capital movements and non-cash transactions | | **187** | | (1,816) | | **-** | | - | |
| Other movements in operating cash flows | | **336** | | 2,925 | | **78** | | 2,560 | |
| | | | **34,483** | | 42,893 | | **34,085** | | 43,313 |
| **Net cash flow from operations** | | | **35,314** | | 41,834 | | **34,979** | | 42,148 |
| | | | | | | | | | |
| **Cash flow from investing activities** | | | | | | | | | |
| Interest received | | **15** | | 384 | | **15** | | 384 | |
| Purchase of intangible assets | | **(2,706)** | | (6,904) | | **(2,706)** | | (6,904) | |
| Purchase of property, plant and equipment | | **(4,003)** | | (11,394) | | **(4,003)** | | (11,394) | |
| **Net cash flow from investing activities** | | | **(6,693)** | | (17,914) | | **(6,693)** | | (17,914) |
| | | | | | | | | | |
| **Cash flow from financing activities** | | | | | | | | | |
| Public dividend capital received | | **282** | | 4,493 | | **282** | | 4,493 | |
| Loans received and received | | **(551)** | | (1,102) | | **(551)** | | (1,102) | |
| Capital element of finance lease rental payments | | **(105)** | | (292) | | **(105)** | | (292) | |
| Interest paid on ITFF loan | | **(225)** | | (472) | | **(225)** | | (472) | |
| Interest element of finance leases | 13 | **(2)** | | (8) | | **(2)** | | (8) | |
| PDC dividend paid | | **-** | | (4,555) | | **-** | | (4,555) | |
| | | | **(601)** | | (1,936) | | **(601)** | | (1,936) |
| **Net increase in cash and cash equivalents** | | | **28,021** | | 21,984 | | **27,686** | | 22,297 |
| Cash and cash equivalents at beginning of period | | | **60,538** | | 38,554 | | **57,753** | | 35,456 |
| **Cash and cash equivalents at end of period** | 19 | | **88,559** | | 60,538 | | **85,439** | | 57,753 |

The notes on pages 18 to 58 form part of these accounts.

# Notes to the accounts

## 1 Accounting policies

### 1.1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

#### Accounting convention

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

#### Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken from outside the public sector. Activities are considered 'discontinued' if they transfer from one public body to another. The Foundation Trust has no acquisitions or discontinued operations to report within these accounts.

#### Critical accounting judgements and key sources of estimation uncertainty

In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount 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 those estimates. The estimates and underlying assumptions are continually revised.

Details of key accounting judgements and estimations are contained within Note 31 to these accounts.

#### Operating segments

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker. The chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Finance and Performance Committee that makes strategic decisions.

#### Accounting standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2020/21. These Standards are still subject to HM Treasury FreM adoption, with IFRS 16 government implemetation date 1st April 2021, and the government implementation date for IFRS 17 on or after 1st January 2023.

- IFRS 16 Leases: Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IFRS 17 Insurance Contracts: Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

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

## Prior period restatements

Each period, the reporting requirements of Foundation Trusts are refreshed, and as a result, some income and expenditure classifications may be updated to improve transparency. In these instances, both the current period and the prior period disclosures are updated. In addition, if in preparing the accounts, corrections are identified to prior period classifications, these will be updated and clearly marked as "restated".

## Basis of consolidation

The consolidated financial statements include the following, in addition to the trust.

## The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund

The NHS Foundation Trust is the corporate trustee of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund (Charity Registration number 1057366). 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.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice, which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

## The Bournemouth Healthcare Trust - Company Registration Number: 06430101

Private Patient services within the NHS Foundation Trust are delivered through The Bournemouth Private Clinic Limited (BPC Company Registration Number 06434541), which is a trading subsidiary of the registered charity, The Bournemouth Healthcare Trust (BHT) (Charity Registration number 1122497). With effect from 1 February 2016, a number of the NHS Foundation Trust directors were appointed as directors on the BPC Board and as Trustees of BHT. This secured a more integrated and robust approach to private patient provision and governance.

As a result of this, the NHS Foundation Trust has reassessed its relationship to BHT (including its trading subsidiary BPC), 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 charity and has the ability to affect those returns and other benefits through its power over the charity.

The charity's statutory accounts are prepared to 30 March in accordance with the UK Charities Statement of Recommended Practice, which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses..

This resulted in £288,000 of income and £288,000 of expenditure being consolidated into the Foundation Trusts accounts togther with a number of Statement of Financial Position balances, most notably the

introduction of the BHT Charitable Fund Reserve, with a closing balance of £1.5 million.

**Christchurch Fairmile Village Limited Liability Partnership: Company Registration Number OC395417**

The Foundation Trust was a voting member of the joint venture, Christchurch Fairmile Village Limited Liability Partnership, which was incorporated on 19 September 2014.

In March 2019, the Foundation Trust sold half of its interest in this LLP. As a result of this, the NHS Foundation Trust has reassessed its relationship to Christchurch Fairmile Village Limited Liability Partnership and determined it to be an associate because the Foundation Trust has the power to exercise significant influence.

The investment will increase or decrease to reflect the Trust's revised share of the entity's profit or loss or other gains and losses (eg revaluation gains on the entity's property, plant and equipment). It is also reduced when any distribution, eg, share dividends are received by the Trust from the associate.

In November 2019 the LLP completed a commmercial transaction resulting in a significant non recurrent profit which is reflected within these accounts.

**Dorset Heart Clinic Limited Liability Partnership: Company Registration Number OC414702**

The Foundation Trust is a voting member of the joint venture, Dorset Heart Clinic Limited Liability Partnership, which was incorporated on 21 November 2016. The joint venture has been consolidated within these accounts using the equity method.

# 1.2 Revenue

## Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the period end, the Trust accrues income relating to performance obligations satisfied in that period. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

## Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

**2020/21**

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

**Comparative period (2019/20) In the** comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the period end, the Trust accrued income relating to activity delivered in that period, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

## Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performamce obligations are satified. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time, depending upon the terms of the contract.

Where income is received for a specific activity which is to be delivered in the following financial period, that income is deferred.

## NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

## Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

## Charitable Funds

Income is received from donations, legacies, fund raising events and from other charitable bodies.

## Education and training

Revenue is recognised when the conditions of education and training contracts have been met.

## Interest

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

### Car Parking

The Foundation Trust operates car parking services for employees and patients. Revenue is recognised when the Foundation Trust collects charges from employees and the public.

### Catering services

The Foundation Trust operates canteen services for employees and patients. Revenue is recognised when the Foundation Trust sells to the employees and the public. Canteen sales are usually by cash or by debit card.

### Rental income

The Foundation Trust owns some residential properties which are let out to members of staff and related parties. Rental income is recognised on a straight-line basis over the term of the lease.

### Income from the sale of non-current assets

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

## 1.3 Expenditure on employee benefits

### Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

### Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

### Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 30 September 2020, is based on valuation data as at 31 March 2020, updated to 30 September 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

### Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

### National Employment Savings Trust (NEST)

The National Employment Savings Trust (NEST) is a defined contribution scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. With effect from 1 May 2013, the Foundation Trust auto-enrols employees into this scheme in line with the national eligibility criteria.

## 1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

## 1.5 Property, plant and equipment

### Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust;
- it is expected to be used for more than one financial period;
- the cost of the item can be measured reliably;
- the item individually has a cost of at least £5,000; or
- collectively, a group of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates, and are under single managerial control; or
- it forms part of the initial equipping and setting-up cost of a new building, refurbishment of a ward or unit irrespective of its individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

### Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. They are measured subsequently at current value.

Non-current assets are stated at the lower of replacement cost and recoverable amount. The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from the financing of the construction of fixed assets are not capitalised but are charged to the Statement of Comprehensive Income in the period to which they relate.

All land and buildings are revalued using professional valuations in accordance with International Accounting Standard (IAS) 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 (Cushman & Wakefield). The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. A full valuation (excluding Assets Under Construction/ Work In Progress) was undertaken as at 31 March 2020, and a desktop valuation (excluding Assets Under Construction/ Work In Progress) was undertaken as at 30 September 2020. This value 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. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Assets in the course of construction are valued at current cost. Larger schemes are valued by the district valuer on completion or when brought into use, and all schemes are valued as part of the three/ five yearly revaluation. Operational equipment is valued at net current replacement cost.

## Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the entity and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is derecognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

## Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. The estimated useful lives of assets are summarised in the table at the bottom of the page.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon this reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

As at 30 September 2020, there were no assets classified as 'Held for Sale'.

| | Minimum Life (years) | Maximum Life (years) |
|---|---|---|
| Buildings and dwellings | 8 | 100 |
| Furniture / fittings | 5 | 20 |
| Set-up costs | 5 | 15 |
| Medical and other equipment | 5 | 15 |
| Vehicles | 7 | 15 |
| Radiology equipment | 5 | 10 |
| IT equipment | 3 | 7 |

## Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

## Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

## De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable, for example:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within twelve months of the date of the classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

## Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/ grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/ grant is deferred within liabilities and is carried forward to future financial periods to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

## 1.6 Intangible assets

### Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust and where the cost of the asset can be measured reliably.

### Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the product is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Foundation Trust intends to complete the asset and sell or use it;
- the Foundation Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits;
- adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset; and
- the Foundation Trust can measure reliably the expenses attributable to the asset during development.

### Software

Software which is integral to the operation of hardware (for example, an operating system) is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware (for example, application software) is capitalised as an intangible asset.

### Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

### Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful live of assets are summarised below:

| | Minimum (years) | Maximum (years) |
|---|---|---|
| Software | 3 | 7 |

## 1.7 Revenue government and other grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups (CCGs), Specialist Commissioners, NHS Foundation Trusts or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

## 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. Due to the high turnover of stocks within the Foundation Trust, current cost is used as a fair estimate of current value.

## 1.9 Financial assets and financial liabilities

### Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

### Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

### Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes current investments, cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

### Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

### De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

## 1.10 Leases

### Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

### Operating leases

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

### Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

## 1.11 Provisions

The Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

### Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 23 but is not recognised in the Trust's accounts.

## Non-Clinical Risk Pooling

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

## 1.12 Contingencies

Contingent assets (that is assets, arising from past events whose existence will only be confirmed by one or more future events not wholly within the Foundation Trust's control) are not recognised as assets, but are disclosed by note where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed by note unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Foundation Trust's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

## 1.13 Public Dividend Capital (PDC) and PDC Dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of International Accounting Standard 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Foundation Trust during the financial period. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) grant funded and assets purchased in repose to COVID-19, (iii) average daily cash balances held with the Government Banking Services (GBS) and National Loan Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to short-term working capital facility, and (iiv) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the period is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

## 1.14 Value added tax

Most of the activities of the Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

## 1.15 Corporation tax

Under current legislation, Foundation Trusts are not liable for corporation tax.

## 1.16 Foreign Exchange

The functional and presentation currency of the Foundation Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

## 1.17 Third party assets

Assets belonging to third parties, (such as money held on behalf of patients) are not recognised in the accounts since the Foundation Trust has no beneficial interest in them. However, they are disclosed within Note 19 to the accounts in accordance with the requirements of HM Treasury's FReM.

## 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature, they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Foundation Trust not been bearing it's own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

## 1.19 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

## 1.20 Going concern

These accounts have been prepared on a going concern basis.

International Accounting Standards (IAS1) require the directors to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 3.20, the accounts should be prepared on a going concern basis unless the directors either intend to apply to the Secretary of State for the dissolution of the Foundation Trust without the transfer of the services to another entity, or have no realistic alternative but to do so.

On 1 October 2020, Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust merged their operations into a single Trust, University Hospitals Dorset NHS Foundation Trust. On the same day, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust was dissolved. Whilst The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust is therefore not a going concern due to its dissolution as part of the merger, the financial statements of the Trust have been prepared on a going concern basis because its services are continuing to be provided by the successor foundation trust.

## 1.21 Investments

The Foundation Trust does not have any investments and the cash is held primarily in the Government Banking Service.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund does hold investments, both Fixed Asset Investments and Short-Term Investments:

### Charitable Fund Fixed Asset Investments

Investment Fixed Assets are shown at Market Value, as detailed in the Statement of Financial Position.

The Trustee's 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 the Statement of Financial Position date are units within a Restricted Investment Portfolio and are included in the Statement of Financial Position at the closing price at 30 September 2020. Investments comprise equities, gilts, other fixed interest investments and pooled funds, the majority of which are quoted investments.

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later).

### Charitable Fund Short-Term Investments

Short-Term Investments include Stocks and Equities that have been received as part of Legacy distributions given to the Charitable Fund. These are revalued at the period-end and any gain or loss on revaluation of the investment asset is shown in the Statement of Comprehensive Income.

## 1.22 IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Foundation Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Foundation Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Foundation Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

# 2 Operating segments

The Foundation Trust has determined the operating segments based on the reports reviewed by the Finance and Performance Committee that are used to make strategic decisions. The Finance and Performance Committee considers the Foundation Trust's business from a services perspective as "Healthcare" and only one segment is therefore reported.

The segment information provided to the Finance and Performance Committee for the reportable segments for the six months ended 30 September 2020 is as follows:

| | Group | | Trust | |
|---|---|---|---|---|
| | **Healthcare 30 September 2020** | Healthcare 31 March 2020 | **Healthcare 30 September 2020** | Healthcare 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Segment revenue | **173,893** | 334,847 | **173,269** | 333,881 |
| Patient and other income | **173,893** | 334,847 | **173,269** | 333,881 |

It is appropriate to aggregate the Trust's activities as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- the nature of the products and services;
- the nature of the production processes;
- the type of class of customer for their products and services;
- the methods used to distribute their products or provide their services; and
- the nature of the regulatory environment.

# 3 Income generation activities

The Foundation Trust has not materially undertaken any other income generation activities with an aim of achieving profit.

The Foundation Trust has been working as part of a joint venture to develop a Nursing Home and Senior Living as part of the Christchurch Fairmile Village LLP as disclosed in Note 1.1. A commercial transaction was undertaken in November 2019 in relation to the Nursing Home, resulting in an operating profit within the LLP. A proportion of the profit attributable to the Trust's share accouting in line with the equity method as disclosed in Note 1.1.

# 4 Operating income

## 4.1 Income from patient related activities

| | Group | | Trust | |
|---|---|---|---|---|
| | **Continuing Operations 30 September 2020** | Continuing Operations 31 March 2020 | **Continuing Operations 30 September 2020** | Continuing Operations 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Foundation Trusts and NHS Trusts | **2,546** | 6,849 | **2,546** | 6,849 |
| Clinical Commissioning Groups | **115,200** | 227,600 | **115,200** | 227,600 |
| NHS England | **28,994** | 58,434 | **28,994** | 58,434 |
| Local authorities | **20** | 252 | **20** | 252 |
| Department of Health and Social Care | **-** | 227 | **-** | 227 |
| NHS Other | **-** | 93 | **-** | 93 |
| Non NHS: | | | | |
| - Private Patients | **1,137** | 3,325 | **849** | 2,445 |
| - Overseas Patients (non-reciprocal) | **20** | 184 | **20** | 184 |
| - NHS Injury Scheme Income | **151** | 351 | **151** | 351 |
| - Other | **-** | - | **-** | - |
| | **148,068** | 297,315 | **147,780** | 296,435 |

The Trust recognises a notional income amount of £4,700,000 for the additional pension contribution that is funded centrally. This is included within the NHS England figures above and is matched by notional expenditure as detailed in Note 7.

The NHS Injury Scheme Income above is reported gross and a 21.89% doubtful debt provision (2019/20: 21.79%) is included in expenditure, which represents expected recovery rates.

## 4.2 Other operating income

| | Group | | Trust | |
|---|---|---|---|---|
| | **Continuing Operations 30 September 2020** | Continuing Operations 31 March 2020 | **Continuing Operations 30 September 2020** | Continuing Operations 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Research and development | **588** | 2,479 | **588** | 2,479 |
| Education and training | **4,723** | 9,487 | **4,723** | 9,487 |
| NHS Charities - capital acquisitions (donated assets) | **-** | - | **28** | 926 |
| NHS Charities - contributions to expenditure | **-** | - | **-** | 241 |
| Received from other bodies: Other charitable and other contributions to expenditure | **717** | 1,634 | **717** | 1,634 |
| Non-patient care services to other bodies | **2,464** | 4,934 | **2,464** | 4,934 |
| National Sustainability Funding | **-** | 7,306 | **-** | 7,306 |
| NHS Charitable Funds: Incoming Resources excluding investment income | **550** | 1,381 | **-** | - |
| DHSC group - consumables donated for COVID response | **2,108** | - | **2,108** | - |
| Top up | **10,846** | - | **10,846** | - |
| Other: | | | | |
| - NHS drug sales | **39** | 31 | **39** | 31 |
| - car parking | **208** | 2,030 | **208** | 2,030 |
| - catering services | **426** | 1,292 | **426** | 1,292 |
| - miscellaneous other | **2,604** | 5,773 | **2,790** | 5,901 |
| Income from operating leases | **552** | 1,185 | **552** | 1,185 |
| | **25,825** | 37,532 | **25,488** | 37,446 |
| | | | | |
| **Total** | **173,893** | 334,847 | **173,269** | 333,881 |

The Trust recognises a notional income amount of £2,108,000 for the Personal Protective Equipment that was centrally procured and provided to the Trust during the COVID response. This is matched by notional expenditure as detailed in Note 7.

# 5 Private patient monitoring

The Foundation Trust has met the requirement in section 43(2A) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purpose of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

# 6 Mandatory and non-mandatory income from activities

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Commissioner requested services | **152,791** | 306,802 | **152,503** | 305,922 |
| Non Commissioner requested services | **21,102** | 28,045 | **20,766** | 27,959 |
| | **173,893** | 334,847 | **173,269** | 333,881 |

# 7 Operating expenses

| | Group | | Trust | |
|---|---|---|---|---|
| | Continuing Operations | | Continuing Operations | |
| | **30 September 2020** | 31 March 20200 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Purchase of healthcare from NHS and DHSC bodies | **1,677** | 4,308 | **1,677** | 4,308 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | **2,255** | 2,928 | **2,255** | 2,928 |
| Purchase of social care | **57** | 153 | **57** | 153 |
| Employee Expenses - Executive directors | **486** | 1,043 | **486** | 1,043 |
| Employee Expenses - Non-executive directors | **77** | 127 | **77** | 127 |
| Employee Expenses - Staff | **108,808** | 205,760 | **108,808** | 205,760 |
| Employee Expenses - Research and development | **1,102** | 2,280 | **1,102** | 2,280 |
| Employee Expenses - Notional employer contributions paid by NHSE (6.3%) | **4,700** | 8,681 | **4,700** | 8,681 |
| Supplies and services - clinical (excluding drug costs) | **12,657** | 32,004 | **12,657** | 32,004 |
| Supplies and services - Notional consumables donated for COVID response | **2,108** | - | **2,108** | - |
| Supplies and services - general | **2,169** | 4,336 | **2,169** | 4,336 |
| Establishment | **802** | 2,634 | **802** | 2,634 |
| Research and development (excluding Employee Expenses) | **132** | 232 | **132** | 232 |
| Transport (staff travel) | **135** | 559 | **135** | 559 |
| Transport (patient transport services) | **200** | 500 | **200** | 500 |
| Premises - Rates | **896** | 1,727 | **896** | 1,727 |
| Premises | **6,506** | 10,245 | **6,506** | 10,245 |

| | Group | | Trust | |
|---|---|---|---|---|
| | Continuing Operations | | Continuing Operations | |
| | **30 September 2020** | 31 March 20200 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Movement in credit loss allowance: all other receivables and investments | **258** | (19) | **258** | (19) |
| Movement in credit loss allowance: contract receivables/assets | **29** | 80 | **29** | 80 |
| Provisions arising / released in period | **178** | (660) | **178** | (660) |
| Change in provisions discount rate(s) | **-** | (77) | **-** | (77) |
| Inventories written down | **86** | 2 | **86** | 2 |
| Drug costs | **15,197** | 33,894 | **15,197** | 33,894 |
| Operating lease payments | **-** | - | **-** | - |
| Depreciation on property, plant and equipment | **3,887** | 8,325 | **3,887** | 8,152 |
| Amortisation on intangible assets | **774** | 658 | **774** | 658 |
| Impairments net of reversals | **651** | 3,193 | **651** | 3,193 |
| Audit fees: | | | | |
| External audit services - financial statement audit | **60** | 68 | **60** | 68 |
| External audit services - audit-related assurance services | **-** | 4 | **-** | 4 |
| External audit services - charitable fund accounts | **-** | 5 | **-** | - |
| Internal Audit and Counter Fraud | **28** | 100 | **28** | 100 |
| Clinical negligence premium | **2,253** | 3,939 | **2,253** | 3,939 |
| Legal fees | **334** | 42 | **334** | 42 |
| Consultancy costs | **3** | 1,098 | **3** | 1,098 |
| Training, courses and conferences | **903** | 1,827 | **903** | 1,827 |
| Insurance | **197** | 335 | **197** | 335 |
| Other services, e.g. external payroll | **280** | 625 | **280** | 625 |
| Losses, ex gratia and special payments | **5** | 16 | **5** | 16 |
| NHS charitable funds: Other resources expended (balance not analysed above) | **400** | 91 | **-** | - |
| Other | **2,772** | 4,843 | **2,486** | 4,252 |
| **Total** | **173,062** | 335,906 | **172,375** | 335,046 |

The Trust has made no donations / contributions to any political party.

# 8 Operating leases

## 8.1 Operating leases as lessor

The Foundation Trust owns some properties from which rental income is derived. These are properties which are leased out to members of staff and the contracts are normally one year. The Foundation Trust also leases some office spaces to some contractors and service providers at the hospital sites. None of the leases include contingent rents and there are no onerous restrictions. The income recognised through the Statement of Comprehensive Income during the period is disclosed as:

| | Group / Trust | |
|---|---|---|
| | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 |
| Operating leases | **552** | 1,185 |
| The future aggregate minimum lease payments under non-cancellable operating leases are as follows: | | |
| No later than one year | **1,012** | 1,074 |
| Between one and five years | **649** | 649 |
| Over five years | **2,629** | 2,668 |
| **Total** | **4,290** | 4,391 |

# 9 Staff costs and numbers

## 9.1 Staff costs

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Salaries and wages | **89,817** | 170,573 | **89,817** | 170,573 |
| Social security costs | **8,475** | 15,890 | **8,475** | 15,890 |
| Employer's contributions to NHS Pensions | **10,668** | 19,887 | **10,668** | 19,887 |
| Apprenticeship Levy | **439** | 826 | **439** | 826 |
| Pension Cost - other contributions | **4,725** | 8,740 | **4,725** | 8,740 |
| Agency/contract staff | **2,110** | 4,536 | **2,110** | 4,536 |
| Capitalised Agency/contract staff | **218** | 294 | **218** | 294 |
| **Total** | **116,451** | 220,746 | **116,451** | 220,746 |

This note excludes Non-Executive Directors, in line with national guidance.

## 9.2 Average number of employees

| | Group | |
|---|---|---|
| | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 |
| Medical and dental | **533** | 507 |
| Administration and estates | **873** | 854 |
| Healthcare assistants and other support staff | **1,380** | 1,391 |
| Nursing, midwifery and health visiting staff | **1,244** | 1,223 |
| Scientific, therapeutic and technical staff | **423** | 408 |
| Healthcare science staff | **82** | 81 |
| **Total** | **4,535** | 4,464 |
| Of which: | | |
| Permanent | **4,503** | 4,086 |
| Other | **32** | 378 |
| **Total** | **4,535** | 4,464 |

This note excludes Non-Executive Directors, in line with national guidance.

## 9.3 Staff exit packages

There were no exit packages in 2020/21 or 2019/20.

# 10 Retirements due to ill-health

There were no early retirements from the Foundation Trust agreed on the grounds of ill-health (2019/20: four). There will be no estimated additional pension liabilities of these ill-health retirements (2019/20: £386,000). Any costs of ill-health retirements are borne by the NHS Pensions Agency.

# 11 Late Payment of Commercial Debts (Interest) Act 1998

There were minimal payments of interest for commercial debts.

# 12 Investment revenue

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Interest on bank accounts | **-** | 398 | **-** | 398 |
| NHS charitable funds: investment income | **1** | 6 | **-** | - |
| **Total** | **1** | 404 | **-** | 398 |

## 12.1 Investment in joint venture

| | Group / Trust | |
|---|---|---|
| | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 |
| Opening Balance | **1,907** | 1,075 |
| Share of profit / (loss) | **305** | 3,768 |
| Disbursements / dividends received | **(397)** | (2,909) |
| Sale of stake | **-** | (27) |
| **Closing Balance** | **1,815** | 1,907 |

The Trust held a 50% share of the Christchurch Fairmile Village Limited Liability Partnership LLP. The joint venture was established during 2014 to operate a residential care home and the sale of retirement living accommodation. On 28th March 2019, the Trust sold a 25% interest in the LLP, leaving the Trust with a 25% interest as at 31 March 2019.

## 12.2 Charity investments

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Opening Balance | **3,990** | 4,204 | **-** | - |
| Movement in fair value | **553** | (214) | **-** | - |
| **Closing balance** | **4,544** | 3,990 | **-** | - |

## 12.3 Other financial assets

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Fixed Deposit (less than one year) | **47** | 47 | **-** | - |
| **Total** | **47** | 47 | **-** | - |

# 13 Finance costs

| | Group / Trust | |
|---|---|---|
| | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 |
| Loans from the Independent Trust Financing Facility | **224** | 472 |
| Finance leases | **2** | 8 |
| Other finance costs | **24** | - |
| **Total** | **250** | 480 |

# 14 Intangible assets, property, plant and equipment

| | Group | | | | | | | | | | | Trust |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Intangible | Tangible | | | | | | | | TOTAL | | TOTAL |
| | Software Licences (incl Work in progess) | Land (Freehold) | Buildings excluding dwellings (Freehold) | Dwellings (Freehold) | Assets Under Construction / Work In Progress | Plant and Machinery | Transport Equipment | Information Technology | Furniture and fittings | Non Current Assets | Less Non-Trust Assets | Trust Assets |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | | |
| Gross cost at 1 April 2020 | 19,640 | 28,187 | 121,303 | - | 6,976 | 49,564 | 376 | 12,125 | 1,067 | 245,094 | 1,218 | 243,876 |
| Additions | 2,362 | - | - | - | 3,024 | 1,332 | - | 447 | 81 | 7,247 | - | 7,247 |
| Additions - leased | - | - | - | - | - | 9 | - | - | - | 9 | - | 9 |
| Additions - donations of physical assets (non-cash) | - | - | - | - | - | 28 | - | - | - | 28 | - | 28 |
| Impairments - Operating expenses | - | - | (629) | (22) | - | - | - | - | - | (651) | - | (651) |
| Impairments - Revaluation reserve | - | - | (1,987) | - | - | - | - | - | - | (1,987) | - | (1,987) |
| Revaluations | - | - | (1,790) | (83) | - | - | - | - | - | (1,873) | - | (1,873) |
| Reclassifications | - | - | 578 | - | (742) | 164 | - | - | - | - | - | - |
| Disposals | (152) | - | - | - | - | (70) | - | - | - | (222) | - | (222) |
| **Cost or valuation at 30 September 2020** | **21,850** | **28,187** | **117,475** | **5,751** | **9,258** | **51,028** | **376** | **12,572** | **1,148** | **247,645** | **1,218** | **246,427** |
| | | | | | | | | | | | | |
| Accumulated depreciation at 1 April 2020 | 7,380 | - | 185 | - | - | 36,148 | 249 | 7,497 | 711 | 52,170 | 1,211 | 50,959 |
| Provided during the year | 774 | - | 1,919 | 77 | - | 1,287 | 14 | 561 | 28 | 4,661 | 1 | 4,661 |
| Revaluations | - | - | (2,104) | (77) | - | - | - | - | - | (2,182) | - | (2,182) |
| Disposals | (152) | - | - | - | - | (70) | - | - | - | (222) | - | (222) |
| **Accumulated depreciation at 30 September 2020** | **8,002** | **-** | **-** | **-** | **-** | **37,366** | **263** | **8,058** | **739** | **54,428** | **1,212** | **53,216** |
| | | | | | | | | | | | | |
| **Net book value** | | | | | | | | | | | | |
| Owned | 12,260 | 28,187 | 114,642 | 5,856 | 6,976 | 10,198 | 125 | 4,602 | 356 | 183,202 | 7 | 183,195 |
| Finance lease | - | - | - | - | - | 452 | - | - | - | 452 | - | 452 |
| Donated | - | - | 6,476 | - | - | 2,766 | 2 | 26 | - | 9,270 | - | 9,270 |
| **NBV total at 31 March 2020** | **12,260** | **28,187** | **121,118** | **5,856** | **6,976** | **13,416** | **127** | **4,628** | **356** | **192,924** | **7** | **192,917** |
| | | | | | | | | | | | | |
| **Net book value** | | | | | | | | | | | | |
| Owned | 13,848 | 28,187 | 111,147 | 5,751 | 9,258 | 10,856 | 112 | 4,492 | 408 | 184,059 | 6 | 184,053 |
| Finance lease | - | - | - | - | - | 300 | - | - | - | 300 | - | 300 |
| Donated | - | - | 6,328 | - | - | 2,506 | 1 | 23 | - | 8,858 | - | 8,858 |
| **NBV total at 30 September 2020** | **13,848** | **28,187** | **117,475** | **5,751** | **9,258** | **13,662** | **113** | **4,515** | **408** | **193,217** | **6** | **193,211** |
| | | | | | | | | | | | | |
| The asset classifications are as follows: | | | | | | | | | | | | |
| - Protected | - | 25,086 | 117,475 | - | - | - | - | - | - | 142,561 | - | 142,561 |
| - Unprotected | 13,848 | 3,101 | | 5,751 | 9,258 | 13,662 | 113 | 4,515 | 408 | 50,656 | 6 | 50,650 |
| **Total** | **13,848** | **28,187** | **117,475** | **5,751** | **9,258** | **13,662** | **113** | **4,515** | **408** | **193,217** | **6** | **193,211** |

The Foundation Trust leases various medical equipment/ IT under non-cancellable finance lease agreements. The lease terms are between five and seven years.

# 14 Intangible assets, property, plant and equipment - Prior Year

| | Group | | | | | | | | | | | Trust |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Intangible | Restated Tangible | | | | | | | | Restated TOTAL | | Restated TOTAL |
| | Software Licences (incl Work in progess) | Land (Freehold) | Buildings excluding dwellings (Freehold) | Dwellings (Freehold) | Assets Under Construction / Work In Progress | Plant and Machinery | Transport Equipment | Information Technology | Furniture and fittings | Non Current Assets | Less Non-Trust Assets | Trust Assets |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | | |
| Gross cost at 1 April 2019 restated | 12,573 | 28,187 | 127,852 | 7,368 | 4,203 | 46,505 | 376 | 11,128 | 965 | 239,157 | 1,212 | 237,945 |
| Additions | 7,067 | - | 1,715 | - | 5,265 | 2,876 | - | 812 | 102 | 17,837 | 6 | 17,831 |
| Additions - leased | - | - | - | - | - | 524 | - | - | - | 524 | - | 524 |
| Additions - donations of physical assets (non-cash) | - | - | - | - | - | 651 | - | - | - | 651 | - | 651 |
| Additions - assets purchased from cash donations/ grants | - | - | 212 | - | - | 29 | - | - | - | 241 | - | 241 |
| Impairments - Operating expenses | - | - | (1,840) | (1,353) | - | - | - | - | - | (3,193) | - | (3,193) |
| Impairments - Revaluation reserve | - | - | (6,207) | - | - | - | - | - | - | (6,207) | - | (6,207) |
| Revaluations | - | - | (2,550) | (159) | - | - | - | - | - | (2,709) | - | (2,709) |
| Reclassifications | - | - | 2,121 | - | (2,492) | 186 | - | 185 | - | - | - | - |
| Disposals | - | - | - | - | - | (1,207) | - | - | - | (1,207) | - | (1,207) |
| **Cost or valuation at 31 March 2020** | **19,640** | **28,187** | **121,303** | **5,856** | **6,976** | **49,564** | **376** | **12,125** | **1,067** | **245,094** | **1,218** | **243,876** |
| Accumulated depreciation at 1 April 2019 restated | 6,722 | - | 126 | - | - | 34,801 | 218 | 6,298 | 665 | 48,830 | 1,037 | 47,793 |
| Provided during the year | 658 | - | 4,304 | 191 | - | 2,554 | 31 | 1,199 | 46 | 8,983 | 174 | 8,809 |
| Revaluations | - | - | (4,245) | (191) | - | - | - | - | - | (4,436) | - | (4,436) |
| Disposals | - | - | - | - | - | (1,207) | - | - | - | (1,207) | - | (1,207) |
| **Accumulated depreciation at 31 March 2020** | **7,380** | **-** | **185** | **-** | **-** | **36,148** | **249** | **7,497** | **711** | **52,170** | **1,211** | **50,959** |
| **Net book value** | | | | | | | | | | | | |
| Owned | 5,851 | 28,187 | 122,963 | 7,368 | 4,203 | - | 154 | 4,791 | 300 | 182,412 | 175 | 182,237 |
| Finance lease | - | - | - | - | - | 6,976 | - | - | - | 215 | - | 215 |
| Donated | - | - | 4,763 | - | - | 6,976 | 4 | 39 | - | 7,700 | - | 7,700 |
| **NBV total at 31 March 2019** | **5,851** | **28,187** | **127,726** | **7,368** | **4,203** | **11,704** | **158** | **4,830** | **300** | **190,327** | **175** | **190,152** |
| **Net book value** | | | | | | | | | | | | |
| Owned | 12,260 | 28,187 | 114,642 | 5,856 | 6,976 | 10,198 | 125 | 4,602 | 356 | 183,202 | 7 | 183,195 |
| Finance lease | - | - | - | - | - | 452 | - | - | - | 452 | - | 452 |
| Donated | - | - | 6,476 | - | - | 2,766 | 2 | 26 | - | 9,270 | - | 9,270 |
| **NBV total at 31 March 2020** | **12,260** | **28,187** | **121,118** | **5,856** | **6,976** | **13,416** | **127** | **4,628** | **356** | **192,924** | **7** | **192,917** |
| The asset classifications are as follows: | | | | | | | | | | | | |
| - protected | - | 25,361 | 119,132 | - | - | - | - | - | - | 144,493 | - | 144,493 |
| - unprotected | 12,260 | 2,826 | 1,986 | 5,856 | 6,976 | 13,416 | 127 | 4,628 | 356 | 48,431 | 7 | 48,424 |
| **Total** | **12,260** | **28,187** | **121,118** | **5,856** | **6,976** | **13,416** | **127** | **4,628** | **356** | **192,924** | **7** | **192,917** |

Included within Buildings above, there are £745,000 of restricted use assets in relation to the Heart Club which is leased to the Bournemouth Heart Club until the year 2046.

| | 2019/20 | 2018/19 |
|---|---|---|
| | £'000 | £'000 |
| Cost | **745** | 746 |
| Accumulated depreciation | **-** | - |
| **Net book value** | **745** | 746 |

The Foundation Trust leases various medical equipment/ IT under non-cancellable finance lease agreements. The lease terms are between five and seven years.

# 15 Impairment of property, plant and equipment

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Changes in market price (as advised by the Trust's external valuer) | **651** | 3,193 | **651** | 3,193 |
| **Total** | **651** | 3,193 | **651** | 3,193 |

# 16 Capital commitments

| | Group | |
|---|---|---|
| | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 |
| Property, plant and equipment | **2,627** | 2,627 |
| Intangible assets | **1,888** | 1,888 |
| Total | **4,515** | 4,515 |

# 17 Inventories

| | Group / Trust | |
|---|---|---|
| | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 |
| Drugs | **1,406** | 1,436 |
| Consumables | **3,004** | 3,380 |
| **Total** | **4,410** | 4,816 |

## 17.1 Inventories recognised in expenses

| | Group | |
|---|---|---|
| | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 |
| Inventories recognised as an expense in the period | **14,538** | 37,593 |
| Notional consumables donated for COVID response | **2,108** | - |
| Write-down of inventories (including losses) | **91** | 125 |
| Reversal of write-downs that reduced expenses | **(5)** | (122) |
| **Total** | **16,732** | 37,596 |

# 18 Trade and other receivables

## 18.1 Amounts falling due within one year:

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Contract receivables (IFRS 15): invoiced | **5,165** | 14,158 | **5,165** | 14,158 |
| Contract receivables (IFRS 15): not yet invoiced / non-invoiced | **4,185** | 4,144 | **3,574** | 3,499 |
| Allowance for impaired contract receivables / assets | **(90)** | (95) | **(90)** | (95) |
| Allowance for impaired other receivables | **(1,939)** | (1,807) | **(1,939)** | (1,807) |
| Prepayments (revenue) [non-PFI] | **3,843** | 2,265 | **3,843** | 2,265 |
| Interest receivable | **-** | 40 | **-** | 40 |
| PDC dividend receivable | **-** | 222 | **-** | 222 |
| Other receivables | **111** | 113 | **1,013** | 783 |
| NHS charitable funds: receivables | **22** | 75 | **-** | - |
| **Total** | **11,297** | 19,115 | **11,566** | 19,065 |
| **Amounts falling due over one year:** | | | | |
| Clinician pension tax provision reimbursement funding from NHSE | **746** | 746 | **746** | 746 |
| **Total** | **12,043** | 19,861 | **12,312** | 19,811 |

The provision for impairment of receivables relates to specific receivables.

*Following the application of IFRS15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown seperately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

## 18.2 Age analysis of trade and other receivables

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| **Age of impaired receivables:** | | | | |
| 0 - 30 days | **57** | 306 | **57** | 306 |
| 31 - 60 days | **17** | 96 | **17** | 96 |
| 61 - 90 days | **54** | 51 | **54** | 51 |
| 91 - 180 days | **373** | 368 | **373** | 368 |
| over 180 days | **1,528** | 1,081 | **1,528** | 1,081 |
| **Sub-total** | **2,029** | 1,902 | **2,029** | 1,902 |
| **Age of non-impaired receivables:** | | | | |
| 0 - 30 days | **6,616** | 10,960 | **6,845** | 10,910 |
| 31 - 60 days | **690** | 2,508 | **690** | 2,508 |
| 61 - 90 days | **210** | 335 | **210** | 335 |
| 91 - 180 days | **1,324** | 2,775 | **1,324** | 2,775 |
| over 180 days | **428** | 595 | **428** | 595 |
| **Sub-total** | **9,268** | 17,173 | **9,497** | 17,124 |
| | | | | |
| **Prepayments** | **-** | 40 | **40** | 40 |
| | | | | |
| **Total** | **11,297** | 19,115 | **11,566** | 19,065 |

## 18.3 Allowances for credit losses (doubtful debts)

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| **Contract receivables and contract assets:** | | | | |
| At 1 April | **95** | 100 | **95** | 100 |
| New allowances arising | **43** | 113 | **43** | 113 |
| Utilisation of allowances (where receivable is written off) | **(33)** | (86) | **(33)** | (86) |
| Reversals of allowances (where receivable is collected in-period) | **(15)** | (32) | **(15)** | (32) |
| **At 30 September / 31 March** | **90** | 95 | **90** | 95 |
| **All other receivables:** | | | | |
| At 1 April | **1,807** | 2,888 | **1,807** | 2,888 |
| New allowances arising | **947** | 975 | **947** | 975 |
| Utilisation of allowances (where receivable is written off) | **(126)** | (1,061) | **(126)** | (1,061) |
| Reversals of allowances (where receivable is collected in-period) | **(689)** | (995) | **(689)** | (995) |
| **At 30 September / 31 March** | **1,939** | 1,807 | **1,939** | 1,807 |

# 19 Cash and cash equivalents

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Balance 1 April | **60,538** | 38,554 | **57,753** | 35,456 |
| Net movement in period | **28,022** | 21,984 | **27,686** | 22,297 |
| **Balance at 31 March** | **88,559** | 60,538 | **85,439** | 57,753 |
| Made up of: | | | | |
| Cash at commercial banks and in hand | **3,480** | 3,263 | **359** | 478 |
| Cash with the Government Banking Service | **85,079** | 57,275 | **85,079** | 57,275 |
| **Cash and cash equivalents** | **88,559** | 60,538 | **85,439** | 57,753 |

The patient monies amount held on trust was £2,563 (2019/20 £5,970) which is not included in the above figures.

# 20 Trade and other payables

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| **Amounts falling due within one year:** | | | | |
| Trade payables | **8,677** | 13,532 | **7,540** | 12,314 |
| Capital payables (including capital accruals) | **2,406** | 1,868 | **2,406** | 1,868 |
| Accruals (revenue costs only) | **22,317** | 21,670 | **22,317** | 21,670 |
| Social security costs | **3,222** | 2,971 | **3,222** | 2,971 |
| VAT payables | **109** | 282 | **109** | 282 |
| Other taxes payable | **1,451** | 1,328 | **1,451** | 1,328 |
| PDC dividend payable | **1,737** | - | **1,737** | - |
| NHS charitable funds: trade and other payables | **864** | 705 | **-** | - |
| **Total** | **40,784** | 42,356 | **38,783** | 40,433 |

This includes outstanding pension contributions at 30 September 2020 of £3,059,000 (2019/20 £2,813,000).

# 21 Other liabilities

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| **Amounts falling due within one year:** | | | | |
| Receipts in advance - Heart club | **15** | 15 | **15** | 15 |
| Receipts in advance - Commissioner contracts | **25,571** | 1,258 | **25,571** | 1,258 |
| Receipts in advance - Grants | **862** | 1,177 | **862** | 1,177 |
| Receipts in advance - Other | **2,821** | 2,429 | **2,821** | 2,429 |
| **Total** | **29,269** | 4,879 | **29,269** | 4,879 |
| | | | | |
| **Amounts falling due over one year:** | | | | |
| Amounts falling due over one year: | **869** | 885 | **869** | 885 |
| **Total** | **30,138** | 5,764 | **30,138** | 5,764 |

# 22 Borrowings

| | Group / Trust | |
|---|---|---|
| | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 |
| Finance lease liabilities | | |
| - Current | **163** | 251 |
| - Non current | **132** | 199 |
| **Total** | **295** | 450 |
| Independent Trust Financing Facility (ITFF) Loan | | |
| - Current | **1,118** | 1,119 |
| - Non current | **13,790** | 14,341 |
| **Total** | **14,908** | 15,460 |

The Trusts ITFF loan relates to the Christchurch Development. It is repayable over 20 years and has a fixed annual interest rate of 2.89%.

# 23 Finance lease obligations

The Foundation Trust operates as lessee on a number of medical equipment leases. These leases generally run for between 5 - 7 years with options to extend the terms at the expiry of the initial period. None of the leases include contingent rents or onerous restrictions on the Foundation Trust's use of assets concerned.

| | Group / Trust | |
|---|---|---|
| | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 |
| **Amounts payable under finance leases** | | |
| Within one year | **165** | 255 |
| Between one and five years | **135** | 203 |
| Less future finance charges | **(6)** | (9) |
| **Total** | **295** | 450 |

# 24 Provisions for liabilities and charges

| | Group / Trust | | | | |
|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | **£'000** |
| | Early Retirement | Injury Benefit | Other Legal claims | Other | **Total** |
| At 1 April 2020 | 211 | 474 | 96 | 1,646 | **2,427** |
| Change in the discount rate | - | - | - | - | **-** |
| Arising during the period | 19 | - | 161 | 245 | **425** |
| Utilised during the period - accruals | (4) | (12) | (2) | - | **(18)** |
| Utilised during the period - cash | (5) | - | (18) | - | **(22)** |
| Reversed unused | - | - | (10) | (2) | **(12)** |
| Unwinding of discount | 1 | (1) | - | - | **0** |
| **At 30 September 2020** | 223 | 461 | 228 | 1,888 | **2,800** |
| **Expected timing of cashflows:** | | | | | |
| Within one year | 19 | 15 | 228 | 499 | **761** |
| Between one and five years | 75 | 62 | - | 644 | **781** |
| After five years | 129 | 384 | - | 746 | **1,259** |
| | 223 | 461 | 228 | 1,888 | **2,800** |

**Current and non current**

Legal Claims

Liability to Third Party and Property Expense Schemes

The Foundation Trust has liability for the excess of each claim.
The calculation is based on estimated claim values and probability of settlement.

Other Claims

Clinician Pension Tax Scheme:

The provision for Clinician Pensions Tax Scheme has been created as at 31 March 2020 and is calculated using the average discounted value per estimated nomination.

Late Payment of Commercial Debts (Interest) Act 1998:

The Foundation Trust has liability for interest and debt collection fees for invoices settled outside terms.

The calculation is based on estimations of invoices settled and probability of a claim being received.

£31,407,000 is included in the provisions of NHS Resolution at 30 September 2020 in respect of clinical negligence liabilities of the Foundation Trust (£23,520,000 at 31 March 2020).

# 25 Related party transactions

The Foundation Trust is a body corporate established by order of the Secretary of State for Health and Social Care.

During the period none of the Board Members or parties related to them has undertaken any material transactions with the Foundation Trust.

During the period the Foundation Trust has had a number of material transactions with public organisations together with other government bodies that fall within the whole of the government accounts boundary. Entities are listed below where the transaction total (excluding recharges) exceeds £500,000:

| | Group / Trust | | | |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| | Income | Expenditure | Receivables | Payables |
| NHS Dorset CCG | 101,014 | 239 | 21 | 17,060 |
| NHS West Hampshire CCG | 13,511 | - | - | 2,252 |
| NHS Bath and North East Somerset, Swindon and Wiltshire CCG | 597 | - | - | 100 |
| Health Education England | 4,364 | - | 11 | 930 |
| NHS Resolution (formerly NHS Litigation Authority) | - | 2,334 | 466 | 4 |
| NHS England - Core | 10,846 | - | 1,569 | 5,185 |
| NHS England - South West RO | 23,398 | - | 358 | - |
| NHS England - South East RO | 964 | - | - | - |
| Dorset County Hospital | 306 | 411 | 140 | 318 |
| Dorset Healthcare Unversity NHS FT | 2,661 | 351 | 2,467 | 363 |
| Poole Hospital NHS FT | 1,774 | 1,905 | 237 | - |
| University Hospitals Southampton NHS FT | 509 | 198 | 30 | 117 |
| NHS Blood and Tranplant | 11 | 724 | - | 177 |
| NHS Pension Scheme | - | 15,368 | - | 3,059 |
| Other transactions less than £500,000 | 11,831 | 149,424 | 5,998 | 40,488 |
| | 171,785 | 170,954 | 11,297 | 70,053 |

The Foundation Trust is an agent on behalf of employees and below are material transactions exceeding £500,000:

| | £'000 | £'000 | £'000 | £'000 |
|---|---|---|---|---|
| | Income | Expenditure | Receivables | Payables |
| NHS Pensions Agency | - | 7,100 | - | 1,242 |
| HM Revenue and Customs | - | | - | 2,152 |
| National Insurance Fund | - | | - | 1,070 |
| | - | 7,100 | - | 4,464 |

# 26 Post statement of financial position events

On 1 October 2020, Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust merged their operations into a single Trust, University Hospitals Dorset NHS Foundation Trust. On the same day, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust was dissolved.

## Analysis of balances transferred to successor organisations

| | Closing balances: | Amounts transferred to: |
|---|---|---|
| | £'000 | **£'000** |
| Summarised final statement of financial position | **RBCH** | **UHD** |
| Non-current assets | 195,772 | 195,772 |
| Current assets | 101,415 | 101,415 |
| Current liabilities | (70,093) | (70,093) |
| Total non-current liabilities | (16,831) | (16,831) |
| **Net Assets** | 210,263 | 210,263 |

# 27 Financial risk management

Financial instruments are held for the sole purpose of managing the cash flow of the Foundation Trust on a day-to-day basis or arise from the operating activities of the Foundation Trust. The management of risks around these financial instruments therefore relates primarily to the Foundation Trust's overall arrangements for managing risks in relation to its financial position.

## Market risk

### Interest rate risk

The Foundation Trust has a fixed rate loan from the Independent Trust Financing Facility; plus capitalised finance lease obligations which each have fixed interest rates. As a result of these fixed rates; any interest rate fluctuations will only affect our ability to earn additional interest on our short-term investments.

The Foundation Trust earned interest of £1,000 during 2020/21, therefore a change in the interest rate would have minimal effect on the amount earned.

### Currency risk

The Foundation Trust has minimal risk of currency fluctuations. Most transactions are in sterling. Although there are some purchases of goods from Ireland, where prices are based on the Euro, all payments are made in sterling.

### Other risk

The inflation rate on NHS service level agreements is based on the NHS funded inflation, and therefore there is a small risk of budgetary financial pressure.

The majority of pay award inflation is based on the nationally agreed Agenda for Change pay scale, and although funding through the Payment by Results (PbR) tariff does not cover the entire cost (there is an assumed efficiency requirement within the tariff), this represents a small risk.

## Credit risk

### Debtor control

The Foundation Trust has a treasury function which includes a credit controller. The Foundation Trust actively pursues debts and use an external company to support specific aged debts.

The majority of the Foundation Trust's payables are short term and the Foundation Trust participates in the national NHS payables reconciliations at 31 December and 31 March each period. This helps to identify any significant NHS receivable queries.

### Provision for doubtful debts

The Foundation Trust reviews non NHS receivables as at 30 September and as a result of this review, has provided £1,284,000 in relation to doubtful debts. A further £90,000 has been provided for in relation to the Injury Scheme, in accordance with scheme guidance.

The Foundation Trust has also reviewed NHS receivables and has provided for doubtful debts amounting to a total of £655,000. This represents either the maximum or probable risk in specific areas and reflects the uncertainty of the financial climate within the healthcare market.

## Liquidity risk

### Loans

The Foundation Trust has a fixed rate loan from the Independent Trust Financing Facility. Repayments commenced in March 2016 and will finish in March 2034.

### Creditors

The Foundation Trust has reported a surplus in the current financial period and continues to have a surplus on the retained earnings reserve. In addition, the Foundation Trust has a cash balance of £85.44m. As such, the Trust is a minimal risk to its creditors.

# 28 Financial instruments

## 28.1 Financial assets

| | Group | | | | Trust | |
|---|---|---|---|---|---|---|
| | **30 September 2020** | | 31 March 2020 | | **30 September 2020** | 31 March 2020 |
| | **£'000** | **£'000** | £'000 | £'000 | **£'000** | £'000 |
| | **Loans and receivables** | **Assets at fair value through Income and Expenditure** | Loans and receivables | Assets at fair value through Income and Expenditure | **Loans and receivables** | Loans and receivables |
| **Assets as per the Statement of Financial Position** | | | | | | |
| Trade and other receivables excluding non-financial assets | **8,178** | **-** | 17,299 | - | **8,178** | 17,299 |
| Other Investments | **3,843** | **-** | 2,265 | - | **3,843** | 2,265 |
| Cash and cash equivalents at bank and in hand | **87,500** | **-** | 59,859 | - | **87,500** | 59,859 |
| NHS charitable funds: financial assets as at 31 March | **1,081** | **4,590** | 753 | 4,037 | **-** | - |
| **Total** | **100,602** | **4,590** | 80,176 | 4,037 | **99,520** | 79,423 |
| | | | | | | |
| **Assets held in £ sterling** | | **105,192** | | 84,213 | **99,520** | 79,423 |

The above amount excludes nil 2019/20 PDC receivables as net payables (2019/20 £222,000).

## 28.2 Financial liabilities

| | Group | | Trust | |
|---|---|---|---|---|
| | **30 September 2020** | 31 March 2020 | **30 September 2020** | 31 March 2020 |
| | **£'000** | £'000 | **£'000** | £'000 |
| | **Other financial liabilities** | Other financial liabilities | **Other financial liabilities** | Other financial liabilities |
| **Liabilities as per the Statement of Financial Position** | | | | |
| Borrowings excluding finance lease and PFI liabilities | **14,908** | 15,460 | **14,908** | 15,460 |
| Obligations under finance leases | **295** | 450 | **295** | 450 |
| NHS trade and other payables excluding non-financial liabilities | **1,228** | 5,351 | **1,228** | 5,351 |
| Non-NHS trade and other payables excluding non-financial liabilities | **32,006** | 31,719 | **32,006** | 31,719 |
| Provisions under contract | **2,795** | 2,427 | **2,795** | 2,427 |
| NHS charitable funds: financial liabilities as at 31 March | **864** | 705 | **-** | - |
| **Total** | **52,096** | 56,112 | **51,232** | 55,407 |
| | | | | |
| **Liabilities held in £ sterling** | **52,096** | 56,112 | **51,232** | 55,407 |

The above amount excludes 2020/21 PDC payables of £1,737,000 (2019/20 nil as net receivables).

The above figures exclude statutory/non-contracted payables of £7,111,000 (2019/20 £7,732,000).

## 28.3 Financial assets / liabilities - fair values

| | Group | | Trust | |
|---|---|---|---|---|
| | 30 September 2020 | | 30 September 2020 | |
| | £'000 | £'000 | £'000 | £'000 |
| | Book Value | Fair Value | Book Value | Fair Value |
| **Financial assets** | | | | |
| Receivables over one year | | | | |
| NHS charitable funds: non-current financial assets | **4,544** | **4,544** | **-** | **-** |
| **Total** | **4,544** | **4,544** | **-** | **-** |
| **Financial liabilities** | | | | |
| Non-current trade and other payables excluding non-financial liabilities | **869** | **869** | **869** | **869** |
| Provisions under contract | **2,800** | **2,800** | **2,800** | **2,800** |
| **Total** | **3,669** | **3,669** | **3,669** | **3,669** |

# 29 Intra-government and NHS balances

| | Group / Trust | |
|---|---|---|
| | 30 September 2020 | |
| | Receivables: amounts falling due within one year | Payables: amounts falling due within one year |
| | £'000 | £'000 |
| Providers | **2,955** | **1,106** |
| NHS and Department of Health | **2,565** | **25,745** |
| Local Government | **163** | **87** |
| Central Government | **13** | **8,021** |
| **Total** | **5,696** | **34,959** |
| | 31 March 2020 | |
| | Receivables: amounts falling due within one year | Payables: amounts falling due within one year |
| | £'000 | £'000 |
| Providers | 8,525 | 4,145 |
| NHS and Department of Health | 6,663 | 2,465 |
| Local Government | 204 | - |
| Central Government | 35 | 7,541 |
| **Total** | 15,427 | 14,151 |

# 30 Losses and special payments

| | Group / Trust | | | |
|---|---|---|---|---|
| | 30 September 2020 | | 31 March 2020 | |
| | **Number** | **£'000** | Number | £'000 |
| **Losses** | | | | |
| Losses of cash due to: | | | | |
| Other causes | **2** | **2** | - | - |
| Bad debts and claims abandoned | **12** | **286** | 10 | 105 |
| **Total losses** | **14** | **288** | 10 | 105 |
| **Special Payments** | | | | |
| Ex gratia payments in respect of: | | | | |
| Loss of personal effects | **9** | **2** | 34 | 6 |
| **Total special payments** | **9** | **2** | 34 | 6 |
| | | | | |
| **Total** | **23** | **290** | 44 | 111 |

There were no cases where the net payment exceeded £10,000.

**Note:** The total costs in this note are compiled directly from the losses and compensations register which reports on an accrual basis, with the exception of provisions for future losses.

# 31 Judgements and estimations

## Key sources of estimation uncertainty and judgements

In the application of the Foundation Trust's accounting policies, the Trust has made estimates and assumptions in a number of areas, as the actual value is not known with certainty at the Statement of Financial Position date. By definition, these estimations are subject to some degree of uncertainty; however in each case the Foundation Trust has taken all reasonable steps to assure itself that these items do not create a significant risk of material uncertainty. Key areas of estimation include:

- Expenditure 'accruals' are included within the total expenditure reported with these financial statements. These accruals represent estimated costs for specific items of committed expenditure for which actual invoices have yet to be received, together with the estimated value of capital works completed, but not formally valued as at 30 September 2020. Estimates are based on the Foundation Trust's current understanding of the actual committed expenditure.
- An estimate of £1.3 million is made in relation to the income due from incomplete patient spells as at 30 September 2020 as the true income in relation to these episodes of care will not be known with certainty until the patient is discharged. This estimate is based on historic trend analysis, together with other relevant factors.
- An estimate is made for depreciation and amortisation of £4.7 million. Each capital or donated asset is added to the asset register and given a unique identifier. The value and an estimated life is assigned (depending on the type of asset) and value divided by the asset life (on a straight-line basis) is used to calculate an annual depreciation charge.

- A net downwards revaluation of land and buildings of £1.7 million has been charged to the revaluation reserve, with a further £0.7 million included within operating expenses. This reflects the desktop valuation of Trust land and buildings carried out by the Trusts external valuers.
- The valuation exercise was carried out in September 2020 with a valuation date of 30 September 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19.

  The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries.

  Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence and published build cost information for comparison purposes, to inform opinions of value. Indeed, the current response to COVID 19 means that we are faced with an unprecedented set of circumstances on which to base a judgement.

  Our valuation is therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty - and a higher degree of caution - should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation of these properties under frequent review.

  For the avoidance of doubt, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. This clause is a disclosure, not a disclaimer. It is used in order to be clear and transparent with all parties, in a professional manner that - in the current extraordinary circumstances - less certainty can be attached to the valuation than would otherwise be the case.

  The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

  Of the £151.413m net book value of land and buildings (including dwellings) subject to valuation, £145.0m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

  A 1% change in the valuation would have £1.51m impact on the statement of financial position with a £53,000 impact on the PDC dividend due to be paid next period and accrued in these financial statements.

# 32 Senior manager remuneration

Directors' remuneration totalled £563,000 for the six months ended 30 September 2020 (2019/20 : £1,170,000). Full details are provided within the Remuneration Report.

# 33 Senior manager pension entitlements

There were benefits accruing to four of the Foundation Trust's Executive Directors under the NHS Pension Scheme in 2020/21. Full details are provided within the Remuneration Report.

# 34 Charitable Fund Reserve

The Charitable Fund Reserve comprises:

| | **30 September 2020** | 31 March 2020 |
|---|---|---|
| | **£'000** | £'000 |
| Restricted funds | **2,376** | 2,279 |
| Unrestricted funds | **1,530** | 1,135 |
| **Total** | **3,906** | 3,414 |

# 35 Subsequent Event

On the 12 March 2021 the Trust received national guidance in relation to the treatment of DHSC outbound stock personal protective equipment (PPE). This requires the Trust to recognise both notional income and expenditure, provided by the DHSC in relation to this stock. The PPE was received from April to September 2020 and was fully utilised in the period.

The Trust recognises a notional income amount of £2,108,000 for the period in relation to the Personal Protective Equipment that was centrally procured and provided to the Trust during the COVID response. This is matched by notional expenditure as detailed in Note 7.

**The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust**

**The Royal Bournemouth Hospital**
Castle Lane East, Bournemouth, BH7 7DW

**Christchurch Hospital**
Fairmile Road, Christchurch, BH23 2JX

Further copies of this report can be found online at
**www.uhd.nhs.uk**

If you would like a copy of the Annual Report and Accounts
in a different format please contact the Communications Department
on **0300 019 4271**