NHS
University Hospitals Dorset
NHS Foundation Trust

Annual Report and Accounts 2020/21

(part-year) 1 October 2020 to 31 March 2021

This is the first Annual Report and Accounts for University Hospitals Dorset NHS Foundation Trust

University Hospitals Dorset NHS Foundation Trust

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

1 October 2020 to 31 March 2021

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

This is the first Annual Report and Accounts
for University Hospitals Dorset NHS Foundation Trust.

© 2021 University Hospitals Dorset NHS Foundation Trust

Contents

Foreword 6
About our Trust 11
Merger - first 6 months 13
Estates and Capital Development 2020/21 13
Sustainability 16
Operational Performance 2020/21 16
Directors' Report 19
Going Concern 31
Council of Governors 31
Nominations, Remuneration and Evaluation Committee (NREC) 34
Membership and Engagement 35
Better Payment Practice Code 36
NHS Improvement's well-led framework 37
Private patient income 37
Board's responsibility for the Annual Report and Accounts 37
Learning from complaints and concerns 38
Stakeholder relations 42
Patient engagement 43
Staff and public engagement 44
Remuneration Report 45
Senior manager remuneration 47
Senior manager pension entitlements 49
Senior Managers' Remuneration Policy 50
Trust Board Members 51
Remuneration Committee 52
Nomination and Remuneration Committee 52
Disclosures required by Health and Social Care Act 53
Staff report 53
The Trade Union 57
Staff Surveys 58
NHS Foundation Trust Code of Governance 60
Annual Governance Statement (1 October 2020 to 31 March 2021) 61

Consolidated financial statements for the six months ended 31 March 2021

Foreword

From our Chief Executive and Chairman

Welcome to the first annual report for University Hospitals Dorset NHS Foundation Trust (UHD). This report covers the first six months of our Trust from 1 October 2020 to 31 March 2021 following the merger of Poole Hospital NHS Foundation Trust with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. It follows on from the final reports of these two trusts which covered the period from 1 April 2020 to 30 September 2020.

Our celebrations for our merger to create UHD were short lived as our first six months of existence were overshadowed by the global Covid-19 pandemic. January was particularly challenging with at one time 435 Covid patients across our hospitals, the highest number we ever had during the whole pandemic, combined with the highest number of staff off that we ever had. The highest number we had during 2020 at any one time of Covid patients was fewer than 90. Over the past year, our staff have cared for more than 3,000 cases of Covid-19, with our experience of the pandemic being characterised by a series of peaks and troughs of demand. Despite all the challenges that we faced, and that at times that we were not able to maintain services to our usual standards, the Trust did incredibly well in maintaining essential services throughout the pandemic.

This included maintaining emergency and urgent care, working in close collaboration with our Dorset partners and colleagues in the private sector. We continued to prioritise high-risk and high-priority treatments, including accessing additional activity within the private sector which were made available as part of a wider national contract. We were very grateful to our local independent sectors partners - in particular, Nuffield Health Bournemouth Hospital and BMI The Harbour Hospital - who worked very closely with our teams to prioritise urgent treatments.

We were particularly proud of our achievements throughout the pandemic in maintaining cancer treatments. Through close collaboration with the independent sector, we were able to maintain treatment for the most clinically urgent patients. Maintaining short waiting times across the cancer pathway is always a priority, and while we didn't always achieve the key cancer waiting times standards, the situation improved after February and we expect this to continue in the future.

Unfortunately, the pandemic required us to halt our routine elective work, which meant that in line with other trusts across the country, our waiting times grew longer than ever before. Therefore, one of our top priorities, working with partners across Dorset, will be to do everything possible to reduce these in 2021/22 - recognising that the pace at which we can do this will be resource dependent.

It is also important to note that the pandemic changed the way in which we delivered services very dramatically, with many teams working in very different ways. A key feature of our recovery plans will therefore be to hold on to these innovations moving forwards, so as to maximise our productivity and make best use of all our resources.

We could not be more proud of how our staff worked together during this time to care for our patients. We would like to take this opportunity to thank all staff across our hospitals 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 were met.

We know though what a toll this took on many of our colleagues, and were glad to have the opportunity to take part in a National Day of Reflection a year on from the first national lockdown on 23 March

2021. Within the Trust, this anniversary was noted on all three of our sites with a service of remembrance led by our chaplains, and a minute's silence at noon. Staff were invited to tie a ribbon on a tree or railing in memory of our patients, and their own family members or friends who have sadly lost their lives to the virus.

As part of our thank you to staff, we sent out a joint letter to colleagues, expressing our heartfelt gratitude for each individual's contribution throughout the Covid-19 pandemic, including as a gesture of our appreciation details of an extra day of special paid leave as a 'Wellbeing Day'. Staff welfare has been a huge focus for our new Trust and we continued to support staff to help them both physically and mentally with a range of offers from on site rest areas to online support. We also provided extra support to our EU colleagues during this period. The UK formally left the European Union (EU) on the 31 December 2020 and the free movement of people, goods and services ceased on 1 January 2021. The Trust has a formal EU Transition Task and Finish Group which continues to monitor and oversee risks and mitigations. Nearly 10 per cent of our colleagues from across our hospitals are from the EU and we will continue to do all that we can to support them.

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.

Colleagues across our hospitals had already been working very closely together prior to our merger and this helped us enormously as we continued to face up to the Covid-19 challenge over the winter. We always knew that we would be stronger working together, and this has certainly been proved throughout the pandemic.

We had approved our Shadow Interim Board in December 2019, and we were delighted that at an extraordinary meeting held on 4 March 2021, the Council of Governors for UHD unanimously endorsed the appointment of our Chair, the Non-Executive Directors and our Chief Executive. This meant that the UHD Board of Directors was formally established and needed no longer to be referred to as being in "interim" form. Our board maintained an oversight of our combined response to Covid-19, making sure that all teams and all three sites worked effectively together (and with partners) to maintain essential services for the local population.

This is one example we can use to demonstrate the benefits of our merger. We need to deliver our merger benefits including patient benefits and have been focussing on ensuring this happens with a new benefit realisation group. We also established a new Transformation and Improvement Group to manage integration, quality improvements and transforming our estate to make it happen. We established our new care group system for overseeing the running of our hospitals and made several key appointments during our first six months. We are very lucky with the high calibre of colleagues working across UHD.

We managed to continue with our plans to transform our hospitals during this time to create the major planned care centre at Poole Hospital and the major emergency care centre at Royal Bournemouth Hospital

for east Dorset. At Poole we started the work to renovate our operating theatres and create new theatres. Work was temporarily delayed as we had to deal with some unforeseen issues with asbestos on site, but we are now on track to transform Poole. At RBH we secured planning permission for the new build of our major emergency, critical care, maternity and children's centre and work has also commenced on this site. We also have ambitious plans for Christchurch Hospital that will help support our ongoing treatment of our patients. This is overall a huge project and we are grateful for the funding as we know what a difference the transformation of our hospitals will make to our patients and for our region.

Alongside our ambitious transformation work for our Trust, we also were pleased to progress the work to identify our new Trust values. Our hugely committed Culture Champions conducted a listening exercise to ascertain the views of staff regarding the values for our new organisation. As well as holding a large number of focus groups and discussions, over 2,000 staff took part in a survey, along with 500 members of the public. The results of this work were then reviewed and themed by our Culture Champions, and presented as recommendations to the Trust Board in October.

Our new UHD values were formally agreed, and are as follows:

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

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

The nominations for the election of public and staff governors for the Council of Governors (CoG) for our new organisations opened on 16 October 2020 and closed on 2 November 2020. The ballot commenced on 20 November 2020, with the declaration of results on 11 December 2020. We are delighted to confirm that the new Council of Governors for UHD was fully established on 1 January 2021 following this process and we welcomed our 21 new public and staff governors, with one vacancy for a staff governor.

Our key stakeholders were also asked to appoint Governors from their respective organisations to join our CoG. These key stakeholders are NHS Dorset CCG, Dorset Council, BCP Council and Bournemouth University. In January 2021, the UHD Volunteers Group nominated a new governor, bringing the total of appointed Governors to five. Each has a tenure of three years from the dates of their respective appointments. We now have 26 individuals on our Council of Governors, with one still to be appointed, from a range of different backgrounds, coming from a range of different constituencies. However, all are joined up in their commitment to the development of UHD, and the delivery of safe, high quality services for local people.

Our partnership with Bournemouth University continued to develop during this time follow our official launch as a university hospital trust from 1 October. This is such an exciting part of our new Trust. Our Board and other colleagues have set in place arrangements to meet regularly with colleagues from Bournemouth University to establish robust governance arrangements and develop our joint five-year strategy. Achieving university hospital status emphasises UHD's

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

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. Our hospitals have a long history of collaborative working with Bournemouth University, which provides a very strong platform moving forwards.

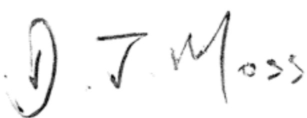
As part of the year's planning guidance, great emphasis was once again placed on strengthening partnership and system working. In this way, partners were expected to better meet the needs of local people and use all resources to best effect. Throughout the Covid-19 pandemic, partners within the Dorset system worked 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".

We are grateful to all our partners across the Dorset Integrated Care System (ICS) including Dorset Healthcare, Dorset County Hospital, BCP Council, Dorset Council, South Western Ambulance Service, the Dorset Clinical Commissioning Group (CCG), Dorset Police and the Dorset and Wiltshire 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.

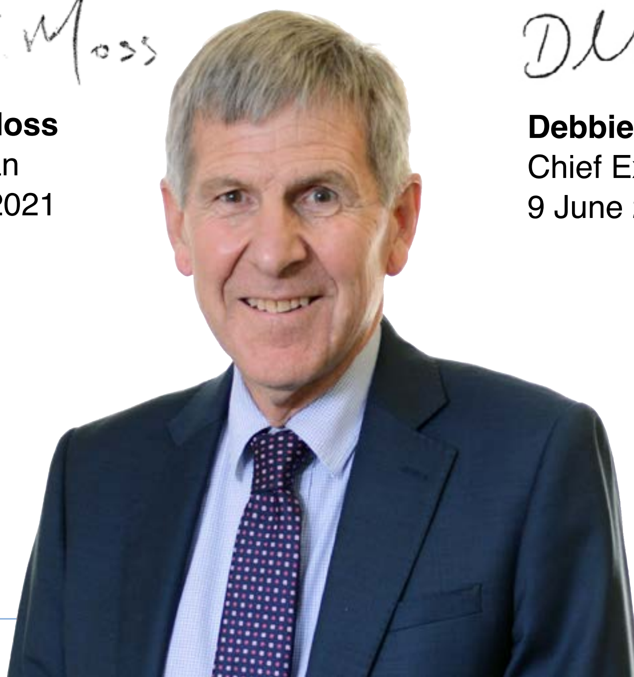
It is anticipated that integrated care systems will play an even more important role in the planning and delivery of integrated local services and in tackling health inequalities. As such our work in developing the Dorset ICS will continue to be a priority going forwards.

Throughout this time, we have been fortunate to have the support of our staff, volunteers, fundraisers, members and, from 1 January 2021, our new Council of Governors. 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 a listening and responsive organisation - one that continues to be valued and highly regarded within our local community.

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



David Moss
Chairman
9 June 2021



Debbie Fleming
Chief Executive
9 June 2021

Our vision

To positively transform our health and care services as part of the Dorset Integrated Care System

Our mission

To provide excellent healthcare for our patients and wider community and be a great place to work, now and for future generations

Our values

We are caring

We are one team

We are listening to understand

We are open and honest

We are always improving

We are inclusive

Our strategic objectives

Be a great place to work

2021/22: nurturing staff wellbeing; having meaningful appraisals; acting on staff feedback; progressing People Strategy; championing equality, diversity and inclusion

Use our resources well

2021/22: restoring our clinical services; achieving our budget; maintaining consistent standards of care; starting our Green Plan

Continually improve quality

2021/22: delivering our priority clinical improvement programmes; transforming outpatient pathways; improving elective and emergency care services; discharging patients who are medically ready as quickly as possible

Be a well led and effective partner

2021/22: communicating more; fostering culture of improvement; developing our leadership; partnering with Bournemouth University

Transform our services

2021/22: creating emergency and planned hospitals; taking forward Health Infrastructure Plan; developing our role in Dorset Integrated Care system; implementing digital transformation strategy

About our Trust

Located about 10 miles apart on the south coast, the Poole, 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 merged to become University Hospitals Dorset NHS Foundation Trust on 1 October 2020. 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.

We provide a wide range of hospital and community-based care to a population of 750,000 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 March 2021 we employed over 9,000 members of staff, both clinical and non-clinical.

Over the six months from 1 October 2020 to 31 March 2021 we cared for and treated the following patients:

- Number of outpatient attendances (follow ups): 260,014
- Number of new outpatient attendances: 144,352
- Number of admissions: 81,114
- Number of attendances to Emergency Department Type 1 and 2*: 65,330
- Number of attendances to Emergency Department* - Urgent Treatment Centre: 7,845

* **Note** - attendances are based on SITREP guidance

Poole Hospital

Poole Hospital is an acute general hospital based on the south coast of England. The hospital has a 24-hour major accident and emergency department and is the designated trauma unit for east Dorset.

The hospital provides general hospital services to the population of Poole, Purbeck and East Dorset as well as a range of additional services such as maternity and neonatal care, paediatrics, oral surgery, ENT and neurology to a wider population including Bournemouth and Christchurch.

In addition, the hospital's flagship Dorset Cancer Centre provides medical and clinical oncology services for the whole of Dorset.

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 Council of Governors, which represents around 15,400 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.

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 subdivides the operational accountability of its clinical services into 3 Care Groups (CG's) and an Operational Support Group supported by corporate services. Within each Care Group, a leadership triumvirate has been established. The structure has been designed to support the delivery of the vision and strategic objectives for the Trust through devolving

leadership and accountability to a local level. 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).

Merger - first 6 months

The completion of the merger transaction on the 1 October 2020 marked the successful end to a decade in which both Poole Hospital NHS Foundation Trust and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust have pursued working together. This started with the joint declaration by both boards, then new legislation prohibited merger in 2013, continued past the Clinical Services Review in 2014-2017 and finishing with various changes in merger date between 2018 and 2020. Navigating the complex regulatory processes along the way, whilst providing CQC "good" services has demonstrated commitment to putting patients ahead of organisational pride.

There has been a wide and diverse range of benefits seen in the first 6 months of merger. Some were planned as part of the merger planning process, some arising by virtue of the changes in both predecessor organisations coming together into University Hospitals Dorset (UHD) and some by way of how UHD responded to the Covid pandemic. It is clear by the progress that has been made in the last six months that UHD is better placed to deliver safe, high quality, sustainable, patient centred services as a single merged Trust than as the previous two discrete Trusts. There is however much still to do. The pandemic has bought about delays in the bringing together of teams at service and function level and planned cultural changes are still very much underway, thus realising the benefits of merger should still be seen as in its early stages.

With the reduction in Covid cases and increase in vaccinations we expect the delivery of merger plans to regain their previous momentum and refreshed plans have been adapted to build on the lessons learned through the pandemic.

Estates and Capital Development 2021

Operational Works

Bringing the 2 estates teams together over the last few months has meant lots of engagement, learning who is who and looking for examples of best practice to deliver estates services at a consistently high standard. We have completed most of the Post-Transaction Integration Plan (PTIP) works identified pre-merger, and are now looking toward the refreshed policies and procedures becoming business as usual.

The roll out of the Quality Management System, into the whole of UHD estates has begun; this will allow us to monitor and improve response times, identify resource requirements and ensure high levels of compliance are achieved. It is expected that this will take at least 12 months to become the norm. Working within the QMS aligns with the GIRFT philosophy; we plan to get "Get It Right First Time". Most of the time!!

The estates teams have been working closely with the capital projects managers to ensure the interface between contractors and the Trust is well managed and that systems for shut downs, closing off areas and maintaining fire escapes etc. are all considered. We have also been working

closely with other teams, including Risk Management and infection control.

The next steps for estates are to consolidate our systems, update asset lists and ensure compliant systems are in place across the entire estate. We have invested significant sums of money in backlog maintenance schemes much of which is not visible to most people; we have replaced boilers, updated ventilation plant, improved water quality, installed LED lighting and improved emergency lighting systems, whilst also upgrading fire alarm systems.

Achieving the level of work we have completed, whilst dealing with the challenges the pandemic has thrown at us has been a remarkable success.

Capital Works

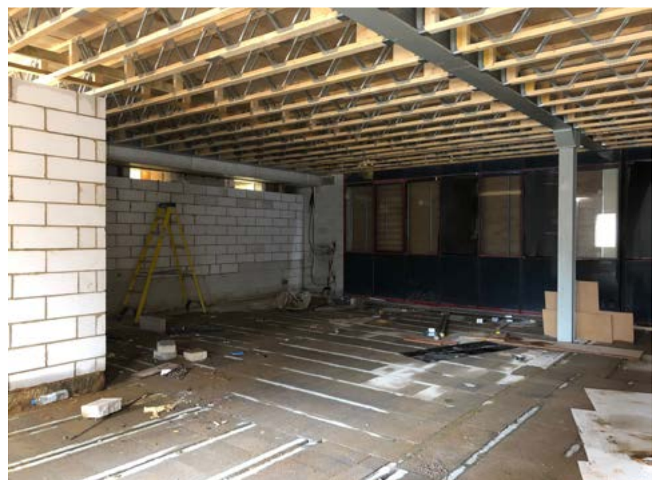
Capital works have begun in earnest on the Poole and Bournemouth Hospital sites. In addition there has been investment in Alderney and the Christchurch hospital. Currently the plans for Pathology building are well developed and work is out to tender, IHP have begun the demolition work to allow the theatre building to progress at Poole, and the enabling works for the major building at RBH; which have also started with services currently housed within the main entrance being moved to new locations outside of the RBH new building footprint. Construction work on the new road has also commenced to reroute traffic around the new building site. This has included having to close public and staff car parking spaces; however we have been able to rent spaces at the Littledown Centre, opposite the hospital for staff use. We have also taken on a lease for a commercial property at Yeomans Way, behind the Castlepoint shopping centre. This building combines both warehousing and office accommodation. Staff will be able to start to use the building, following its refurbishment, in the late summer this year.

There are a few images below that show just some of the works being undertaken at the moment, they represent just a small sample of the whole capital projects list that runs to over 60 schemes across the UHD estate.

UHD - Pathology Laboratory.

New MRI at Poole.

The construction of a new retail pharmacy is ongoing. The relocation of the reception to a new West Entrance is underway and the final design of the new state of the art pathology unit is almost complete.



Pharmacy extension.

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.

Christchurch hospital Therapy Services.

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 over the past year and further projects are currently in design for upgrading equipment and infrastructure at the site.

It has been an incredibly busy period for the capital team, the continued 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 embed sustainably across the organisation.

The Trust sustainability policies are mapped out in our sustainable development plan, supported by the Trust waste policies, sustainable procurement strategy and travel and active travel policy. Together, these policies frame our approach to responsible management of energy and water consumption, carbon emissions, waste and improve our contributions to the UN sustainability goals.

The Trust has appointed a sustainability lead on the board and also a dedicated sustainability manager as part of a growing sustainability team which aims to embed sustainability throughout the organisation. This year has been challenging on many fronts and we have seen an increase in infectious clinical waste volumes due to the pandemic, however, despite the challenges, we have implemented new waste reduction and segregation measures such as a PC refurbishment scheme, carried out a series of green clinical projects and prepared the ground for a new level of sustainability ambition which will be captured in a revised to be Green Plan published in June 2021.

Operational Performance 2020/21

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.

Internally 'Ward to Board' reporting structures which reflect the clinical services of the newly merged Trust and the performance reporting arrangements support the scrutiny of performance.

Effective scrutiny relies primarily on the provision of clear comprehensive summary information to the Board and its Committees and through a range of documents, including:

- Integrated Performance Report (IPR)
- Ward to Board report
- Care group performance review

The Integrated Performance Report (IPR) is in place for monitoring the agreed key performance indicators against key national and local quality, operational, finance and workforce targets. It provides the Trust Board and Committees with the Trust's performance against key indicators and draws attention to those areas requiring

additional review through an escalation report.

Both Poole Hospital and The Royal Bournemouth and Christchurch Hospitals have historically had a track record for strong performance against national and local standards, and we are proud of the performance indicators we have achieved this period as University Hospitals Dorset, despite the challenges of Covid.

Our quality strategy is designed to support the achievement of the strategic objectives, but specifically ensures that safe, responsive, high quality care is delivered through robust quality governance arrangements. Progress, achievements, actions and learning are monitored via the Quality Committee and Trust quality governance and risk management framework. The Quality Committee is a subcommittee of the Board and is chaired by a non-executive director. The Quality Committee receives regular reports from the clinical care groups and committee sub groups to ensure routine monitoring of processes in place to ensure patient and staff safety, maintain quality and optimise clinical effectiveness. During each year we also engage regularly with our external partners and stakeholders who all contribute to the quality monitoring process and identification of ongoing quality improvement goals.

Risk of inequalities in the way care is delivered

We have partnered with Optum UK to develop an advanced data analytics approach to account for the risks of inequalities arising in the way care is delivered and the increased population waiting for elective care. Through the use of linked data systems we will be gaining a deeper insight into elective care issues and a detailed analysis of the primary care, acute care, mental health and community care to reveal populations at risk of inequity in care. Using a focussed task and finish approach we will ensure that we make predictions about the areas where inequity could arise and make robust efforts to avoid it.

How we have performed during the second half of 2020/21

Since March 2020 our combined focus 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 whilst also complying with national infection control guidance and the use of Personal Protective Equipment (PPE) and social distancing. The result of complying with these infection control measures was that less activity was undertaken in re-established outpatient, procedure and theatre sessions for some specialities. This has impacted on the performance reported against the operational standards.

From October 2020 the newly merged Trust was focussed on operational planning for winter and preparations for responding to further waves of Covid-19. This was in-conjunction with a continued focus on cancer and urgent elective activity. In the second half of 2020/21 the Bournemouth, Christchurch & Poole area experienced some of the highest rates of Covid-19 infection in the South West of England. This resulted in a significant increase in demand and operational pressures for the Trust. By the start of March 2021, the number of new cases of Covid and number of patients in hospital were on the decline and recovery of performance has commenced.

In relation to emergency care, both the RBCH and Poole emergency departments experienced a significant increase in demand over the winter period. Covid-19 significantly impacted on department capacity and flow. Increasing numbers of covid positive patients, increased occupancy across the organisation and reduced hospital flow, created increased pressures in the emergency departments/admission portals and increased ambulance handover and wait to be seen times. This is reflected in the mean wait time performance against the national pilot scheme ED mean time standard. Attendances to the emergency department and emergency admissions for non-Covid reasons also started to increase during February and in to March.

During the second half of 2020/21, the demand for elective care has increased significantly compared with the first six months, particularly in the number of cancer fast-track referrals. In response, the levels of activity in both elective in-patient and outpatients have increased over the first half of the year but remain below the same period in 2019/20 due to the impact on capacity of the Covid-19 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 the increasing number of covid-19 positive patients occupying beds, staffing shortages compounded by the pandemic and increasing demand.

With a decrease in the number of covid-19 positive patients occupying beds at the end of February 2021, the focus in March 2021 has been on elective recovery and restoration with action plans 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. This then constrains capacity for planned surgery and impacts on waiting times.

The Trust is working with partners across the Dorset system to manage the capacity and constraints.

The strong recovery in the DM01 diagnostic access standard during the first half of the year continued through the second half of the year. Performance in March 2021 was 2.9%, an improvement from the October 2020 position. This is despite endoscopy activity being reduced in January and February as the service deployed staff to support wards and critical care during the 3rd Covid-19 wave. The improved performance has been achieved with the additional temporary endoscopy capacity on the RBH site and reviewing all endoscopy activity in the Dorset system to reduce waiting times.
Cancer referral numbers continue to exceed previous years putting additional pressure of several services at all stages of the pathway. Despite these pressures the Trust achieved the 28 day Faster Diagnosis and 31 day Cancer standards. The 62-day standard was not met over the 6 month period. Diagnostic waits and late referrals have been contributing factors alongside surgical capacity.

Clinical Performance

Performance Metric	Target	UHD Perfomance Oct 20 - Mar 21
Mean wait time in Emergency Dept	200	230.9
Diagnostic 6 week standard - % greater than 6 weeks	1%	2.9%
Referral to Treatment - % patients within 18 weeks	92%	58.20%
Referral to Treatment - number of pathways	45,227	47,133
28 day Faster Diagnosis Standard	75%	79.90%
31 day Cancer Standard - % patients diagnosed being treated within 31 days	96%	96.90%
62 day Cancer Standard - % patients being seen 62 days from urgent GP referrals	85%	78.40%

Debbie Fleming, Chief Executive
9 June 2021

Directors' Report

Introduction

The board of directors is made up of eight executive directors and eight non-executive directors, including the Chair. The board of directors is responsible for setting and achieving the long term strategic goals and key objectives of the foundation trust and ensuring that it meets the terms of its licence. 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.

Key activities of the Board of directors

The board of directors is made up of executive directors and non-executive directors. The board usually meets every month and its role is to determine the overall corporate direction of the trust and ensure delivery of our goals, contractual targets and regulatory requirements. The board has reserved powers to itself covering:

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

The board delegates areas of its powers to its committees (not including executive powers unless expressly authorised).

The schedule of delegation for the board committees and for the executive committee of the trust is set out in standing orders.

The trust has various routes for resolving disagreements between the board of directors and the council of governors. These include the interventions of the senior independent director and the Lead Governor (who is a governor). There is also a formal position for resolving any disagreements which can be found at:

www.uhd.nhs.uk/uploads/about/docs/our_publications/Board_Policy_for_engagement_with_CoG_October_2020.pdf

Non-executive directors may have their tenure terminated by their own resignation, through the intervention of NHS England and Improvement or a decision by the council of governors based on the approval of three quarters of the members of the council of governors.

The trust has a formal statement regarding the division of responsibilities between the chairman and chief executive as required by Monitor's (now NHS Improvement's) code of governance and this can be found on our website:

www.uhd.nhs.uk/uploads/about/docs/our_publications/D23_Chairman_v_Chief_Executive_Resposibilities_Statement_October_2020.pdf

Board development and evaluation

The board has also been fully cognisant of its own development needs and established a programme of development seminars on a monthly basis from the Trust's inception on 1 October 2020. These have included: Sustainability and the new organisations priorities; Equality, Diversity and Inclusion; NHSI's presentation and briefing on Digital Boards; integrated care systems, partnership working with Bournemouth University.

The board has also commissioned the internal auditors BDO LLP to conduct a Board Effectiveness review following the establishment of the new trust which will be finalised in summer 2021.

Working with governors

The trust has a formal engagement document which was approved by the board of directors in January 2021 and presented to the council of governors also in January 2021, that sets out how the board of directors works with the council of governors to ensure the directors have an understanding of the views of governors and members and directors are invited to the council of governors meetings. The document underlines the importance of frequent informal communication in building a positive and constructive relationship, and outlines formal communication methods and can be found on our website.

Members of the board of directors

Non- executive directors

David Moss
Chair
Date of appointment:
1 October 2020
Date of expiry:
30 September 2023

David has been chair of both the Royal Bournemouth and Christchurch Hospitals and Poole Hospital NHS Foundation Trusts. On 1 October 2020, he became chair of University Hospitals Dorset NHS Foundation Trust and has responsibility for chairing both the Board of Directors and the Council of Governors and their nomination and remuneration committees. David has extensive experience of working within the NHS locally and nationally and was previously chief executive officer at both Poole Hospital and University Hospital Southampton. While at Southampton he led the reconfiguration of acute services across 10 hospitals and the creation of University Hospitals Southampton.

Locally he has also been director of finance for East Dorset Health Authority, chair of governors of Ferndown Upper School and is vice president of the Hospital Services Cricket Club. At national level he has been deputy director of human resources for the NHS, chief executive officer of the Royal College of Physicians, chair of the UK University Hospitals Association and a non-executive director of the Audit Commission.

Philip Green
Vice chair, chair of the Audit Committee
Date of appointment:
1 October 2020
Date of expiry:
30 September 2023

Philip had 40 years' experience working in the aerospace and defence sector, firstly at BAE Systems PLC and then at Meggitt PLC, where he was a member of the Board of Directors for 19 years. He retired from Meggitt at the end of 2019, where he held the position of Executive Director, Commercial and Corporate Affairs responsible for commercial, legal and compliance matters as well as UK and US government relations.

Philip was appointed a non-executive director of Poole Hospital NHS Foundation Trust in 2015. He also served as vice chair of the trust and chair of the audit and governance committee. As of 1 October 2020, Philip is now the vice chair of University Hospitals Dorset NHS Foundation Trust and chair of the audit committee. Philip is also a member of the Trust's Quality, Sustainability and Charitable Funds Committees.

Stephen Mount
Chair of the Finance and Performance Committee
Date of appointment:
1 October 2020
Date of expiry:
30 September 2023

Stephen is an independent non-executive director and audit committee chair of Gama Aviation Plc, and a member of the regulatory decisions committee of the Financial Conduct Authority. He chairs the finance and performance committee and sits on the audit, workforce strategy and sustainability committees at University Hospitals Dorset NHS Foundation Trust. Stephen acts internationally as an expert witness on auditing, financial reporting and corporate governance matters, and serves as a governor of Reading Blue Coat School. Previously he was a member of the audit quality review committee of the Financial Reporting Council, and was a trustee and treasurer of New Forest Heritage.

Stephen retired as a senior partner with PwC in 2016, after almost three decades auditing and advising FTSE, Fortune 500 and smaller/midcap listed companies in the UK, USA, Europe and Asia across a wide range of industry sectors. His experience gained from leading and participating in main board and audit committee meetings, and with investment bankers, investors and other advisors is comparable to having served as an independent non-executive director with over 40 publically listed companies. He is a fellow of the Institute of Chartered Accountants in England and Wales.

Caroline Tapster CBE
Senior independent director and chair of the Quality Committee
Date of appointment:
1 October 2020
Date of expiry:
30 September 2023

Caroline Tapster CBE has spent the last 30 years working in local government and the NHS, in Dorset, East Sussex and Kent. She joined Hertfordshire County Council in 1995 becoming Director of Adult Care Services in 2001, and was appointed Chief Executive in 2004. During this time she was a Governor of Oakland’s FE College, President of Hertfordshire Agricultural Society, a Board member of Hertfordshire PCT, and was awarded an Honorary Doctorate from the University of Hertfordshire.

She has been a Board Member of SOLACE, a past Chairman of ACCE, a member of numerous National Advisory Groups and Government Reviews and has served as a non-executive director of the Disclosure and Barring Service and as a Trustee of the Terence Higgins Trust. She is currently Director of Health and Wellbeing System Improvement for the Local Government Association.

Pankaj Dave
Chair of the Transformation Committee
Date of appointment:
1 October 2020
Date of expiry:
30 September 2023

Pankaj is a chartered certified accountant and has worked internationally as a senior executive leading large multidisciplinary teams for a range of globally recognised businesses including BP, Amoco and Reliance Industries. He has broad business experience having worked in strategy, finance, commercial, business transformation, operations, enterprise systems implementation and planning and performance management roles. Pankaj was a Board Trustee with Kidney Research UK and ran his strategy consultancy business. In his last role Pankaj worked for five years as an expat for Reliance Industries, India's largest company. As a direct report to the managing director, he led and successfully delivered a major group-wide transformation programme to integrate processes, systems, data and organisation and to design and implement the group management systems and governance framework.

Pankaj chairs the Transformation Committee for University Hospitals Dorset NHS Foundation Trust (UHD) and is a member of the UHD Audit and Finance and Performance Committees. He is also a Board Trustee with the Royal College of Surgeons (Eng) where he chairs the audit and risk committee.

Cliff Shearman
Chair of the Workforce Strategy Committee
Date of appointment:
1 October 2020
Date of expiry:
30 September 2023

Cliff Shearman was appointed as a non-executive director on 1 October 2020. Cliff lives in West Hampshire and 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 2007-2012. Cliff is now emeritus professor of vascular surgery at the University of Southampton.

Cliff has been heavily engaged in quality improvement work relating people with diabetes to improve the quality of care and 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. He is also a trustee of the Royal College of Surgeons. Cliff is a non-executive director on the board of Spire Health Care.

Cliff chairs the workforce strategy committee and is a member of the quality committee.

John Lelliott OBE
Chair of the Charitable Funds Committee and Sustainability Committee
Date of appointment:
1 October 2020
Date of expiry:
30 September 2023

John had a long career in public service, retiring from The Crown Estate in September 2016 where he held the position of finance director. John also held the positions of non-executive director and chair of the audit committees' of the Environment Agency and the Covent Garden Market Authority, chair of the Natural Capital Coalition from July 2016 to July 2019, and now a board member of the Capitals Coalition. In addition, John was chairman of the ACCA Global Sustainability Forum, a member of HRH The Prince of Wales Accounting for Sustainability Project (A4S) advisory Council and is an international integrated reporting council (IIRC) ambassador.

John was a trustee and vice chair of Asthma UK until July 2016.

John is a qualified chartered certified accountant and a fellow of the Chartered Association of Certified Accountants. John joined the trust's board of directors as a non-executive director on 1 October 2020 having previously been on the board of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust since 2016. John chairs the UHD charity committee and the sustainability committee. He is also a member of the finance committee and the audit committee.

Christine Hallett
Date of appointment:
1 October 2020
Date of expiry:
30 September 2023

Christine Hallett worked at the Department of Health for four years before moving to 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 UK Council for International Student Affairs and as a member of the Council of Governors at Bournemouth University.

Christine is a member of the quality committee, the workforce strategy committee and the charitable funds committee

Executive Directors

Debbie Fleming
Chief executive
Date of appointment:
1 October 2020

Debbie Fleming is the first chief executive for University Hospitals Dorset NHS Foundation Trust, established on 1 October 2020.

Debbie was appointed chief executive for Poole Hospital NHS Foundation Trust in 2014 where she served for five years before being appointed as chief executive to the Royal Bournemouth and Christchurch NHS Foundation Trust.

From January 2019, she led the merger of the two organisations, as joint chief executive over both.

She chairs the Dorset Cancer Partnership and leads on the transformation of Planned Care Services within the Dorset Integrated Care System.

Mark Mould
Chief operating officer
Date of appointment:
1 October 2020

Mark Mould is the first Chief Operating Officer for University Hospitals Dorset NHS Foundation Trust, established on 1 October 2020.

Mark was previously the Chief Operating Officer for Poole Hospital NHS Foundation Trust where he served for six years.

Mark has extensive operational management experience across a number of other acute trusts across the country.

Paula Shobbrook
Chief nursing officer
Date of appointment:
1 October 2020

Paula has extensive executive and nursing leadership experience in acute hospitals, having worked in two executive nurse director roles prior to her appointment to UHD. She was director of nursing and midwifery at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust from September 2011 and executive chief nurse at Winchester and Eastleigh Healthcare NHS Trust where she worked for 10 years. Paula's nursing career includes clinical experience in acute medicine, cardiac and respiratory specialties and her areas of particular interest are quality governance, patient safety and leadership development.

Paula is a Visiting Professor at Bournemouth University, Faculty of Health and Social Sciences. She was appointed Deputy Chief Executive for UHD in November 2020.

Pete Papworth
Chief finance officer
Date of appointment:
1 October 2020

Pete was appointed director of finance for the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in 2017 and was subsequently appointed director of finance for Poole Hospital NHS Foundation Trust in 2019 in a joint role across both organisations. Pete led the financial aspects of the merger of the two organisations and was appointed as the first chief finance officer for University Hospitals Dorset NHS Foundation Trust on 1 October 2020.

Pete is a chartered accountant with experience working across all aspects of the public sector locally, since joining the Audit Commission's graduate scheme in 2003.

Dr Alyson O'Donnell
Chief medical officer
Date of appointment:
1 October 2020

Alyson joined the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust as medical director in November 2016 before being appointed the role of chief medical officer for the UHD. Alyson comes from a clinical background as a consultant neonatologist, having completed her professional training in both the UK and Australia.

She has extensive experience in the leadership and development of clinical networks and their impact on clinical care. She is passionate about using quality improvement to drive patient outcomes and the role of medical leadership in ensuring an embedded safety and learning culture.

Richard Renaut
Chief strategy and transformation officer
Date of appointment:
1 October 2020

Richard joined the NHS through the NHS management training scheme. He has worked in both primary care and tertiary hospital settings. Prior to his appointment as chief strategy and transformation officer on 1 October 2020, Richard was chief operating officer and has been a board executive since 2006.

Karen Allman
Chief people officer
Date of appointment:
1 October 2020

Karen was appointed to the role of chief people officer for the new UHD on 1 October 2020, having previously been the director of human resources for the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust since 2007. She joined the NHS in 2003 from the Audit Commission where she was human resources director for District Audit. Her early career was spent in the private sector in retail with Marks & Spencer and Fenwick before working in the city at the London Stock Exchange.

Peter Gill
Chief informatics and IT officer
Date of appointment:
1 October 2020

Peter was appointed the role of chief informatics and IT officer for UHD and has been director of informatics for the two preceding Trusts since 2012. In the new role, Peter remains responsible for the informatics service comprising of around 150 team members who make a significant contribution to the running of the trust 24 hours a day, seven days a week. Over eight years in London, he held two previous director of informatics roles and was head of informatics at Salisbury Foundation Trust for two years. Peter has been working in the NHS continuously from 1991 where he joined as a general management trainee. Peter is responsible for delivering the digital transformation strategy which aims to improve patient safety by implementing paperless healthcare and supporting all clinical and non-clinical services to realise the benefits of adopting digital solutions. Peter has a degree in mathematics and management sciences and a masters in leadership through effective human resource management. In his spare time you might spot Peter running or cycling in Dorset.

Details of all the Board members and their declarations of interest can be viewed on the Trust's website:

www.uhd.nhs.uk/uploads/about/docs/our_publications/D5_Register_of_Directors_Interests.pdf

In compliance with paragraph B.3.3 of the Monitor code of governance for NHS foundation trusts, no executive director holds more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity during October 2020 to March 2021.

All of the non-executive directors are considered to be independent by the board of directors.

A director is regarded as having taken all the steps that they ought to have taken as a director in order to do the things mentioned above, and:

- Made such enquiries of his/her fellow directors and of the company's auditors for that purpose; and
- Taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the company to exercise reasonable care, skill and diligence.

The board of directors has approved a policy for the provision of any non-audit service that might be provided by the trust's external auditor. This policy removes any unnecessary restrictions on the purchase of services from the external auditor but ensures that any non-audit service provided by them cannot impair or cannot be seen to impair the objectivity of their opinion on the financial statements.

Board meetings

The board of directors meets every month on the last Wednesday of the month and at other times as necessary (Note: meets every month, and every other month in public). 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. All meetings of the Board were held virtually using Microsoft Teams.

Opposite each name in the table shown below is 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	Chief People Officer	5 (5)
Pankaj Davé	Non-Executive Director	5 (5)
Debbie Fleming	Chief Executive	5 (5)
Peter Gill	Chief Informatics and IT Officer	5 (5)
Philip Green	Non- Executive Director	5 (5)
Christine Hallett	Non- Executive Director	4 (5)
John Lelliott	Non-Executive Director	5 (5)
David Moss	Chair	5 (5)
Alyson O'Donnell	Chief Medical Officer	5 (5)
Name	**Title**	**Attendance**
Mark Mould	Chief Operating Officer	4 (5)
Stephen Mount	Non- Executive Director	5 (5)
Pete Papworth	Chief Finance Officer	4 (5)
Richard Renaut	Chief Strategy and Transformation Officer	5 (5)
Cliff Shearman	Non-Executive Director	4 (5)
Paula Shobbrook	Chief Nursing Officer	4 (5)
Caroline Tapster	Non- Executive Director	5 (5)

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 Chief Finance Officer, Chief Nursing Officer, Chief Medical Officer, Chief Informatics and IT Officer, and representatives from the risk management and clinical audit teams also regularly attend meetings at the request of the Chairperson. The Audit Committee met three times during the period. The committee members are all independent Non-Executive Directors and during the reporting period attended meetings as follows:

Name	Meetings attended
Philip Green (Chair)	3 (3)
Stephen Mount	3 (3)
Pankaj Davé	3 (3)
John Lelliott	3 (3)

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.

Full terms of reference for the committee can be found on our website:

www.uhd.nhs.uk/uploads/about/docs/our_publications/Audit_Committee_Terms_of_Reference_V1.pdf

Internal audit

Internal auditors assist the audit committee by providing a clear statement of assurance regarding the adequacy and effectiveness of internal controls. The director of finance is professionally responsible for implementing systems of internal financial control and is able to advise the audit committee on such matters. The internal audit function is provided by BDO. Internal Audit has reported as follows:

Overall, we are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently.

External auditors

The role of external auditors is to provide an independent audit opinion on the annual report and accounts, as well as providing a limited assurance opinion on the quality report although such a report was not required for the reporting period.

The key elements for the framework of assessment of effectiveness of the external audit process employed by the director of finance include a review of performance in relation to the contracted service specification, the standard of audits conducted, the recording of any adjustments, the timeliness of reporting, the availability of the Auditor for discussion and meetings on key issues, and the quality of reporting to the Audit Committee, the board of directors and the council of governors. Using this framework the chief finance officer is satisfied with the effectiveness of the external audit process.

The significant audit risks which were identified as part of the overall audit were:

- fraud risk in relation to revenue recognition
- fraud risk in relation to non pay expenditure recognition
- valuation of land and buildings
- management override of controls.

These were agreed with the audit committee as part of the audit planning process, and KPMG reported on these areas as part of their year end report. No significant issues were identified.

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 (FTSUG). The non-executive lead responsible for speaking up 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.

Part of this governance includes Helen Martin (FTSUG) meeting Christine Hallett (NED) every 4-6months. In addition, job roles and responsibilities based on the NHSI/E toolkit, have been shared with every member of the board.

Appointments and Remuneration Committee

The appointments and remuneration committee makes the executive appointments to the board of directors and approves the remuneration of the executive. It is made up of the chairman and non-executive directors of the board of directors. The chief executive attends except when the appointment of the chief executive is discussed. The chief people officer attends except when his/her own appointment is discussed. Appointments to executive director posts are made in open competition and can only be terminated by the board of directors.

Going Concern

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Council of Governors

There are 27 members of the Council of Governors including seventeen elected public governors, five elected staff governors, and five nominated by partner organisations 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.

The council plays a role in helping to set the overall strategic direction of the organisation by advising the board of directors of the views of the constituencies they represent. It also has specific responsibilities, set out in the National Health Service Act 2006 and the Health and Social Care Act 2012, in relation to the appointment or removal of non-executive directors and their remuneration, the appointment or removal of the trust's auditors and development of the membership strategy.

The trust is committed to embedding transparency and accountability throughout. The trust recognises it has a specific responsibility to inform NHS Improvement of any potential breach of the provider licence at the earliest practicable opportunity. The trust believes that its robust and effective engagement policy would ensure this is done should it be necessary. The trust does not currently foresee any circumstances whereby it would be necessary for the governors to

have to inform NHS Improvement of any possible breaches.

The council is chaired by the chair of the trust, and Caroline Tapster, non-executive director was the senior independent director for the period of this report and was available to the council of governors if they had concerns about the performance of the board of directors, compliance with the provider licence or welfare of the trust, which contact through the normal channels of chair or chief executive, failed to resolve or for which such contact is inappropriate.

The council's lead governor and deputy lead governor will be determined in April 2021.

Governor training and development

All governors are provided with an induction and receive appropriate updates on the publications; "Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors" and the "Guide to Monitor for NHS Foundation Trust Governors". These documents are also supported by a trust governor reference manual.

The council is kept fully informed through governor briefings.

The council will continue to develop further the membership and its engagement with members through the overarching membership strategy and the membership engagement group.

The chair takes steps to ensure that governors have the skills and knowledge they require to undertake their role. This includes access to a comprehensive induction process and development training events.

Elections

Elections were held in December 2020 across all constituencies to form the Council of Governors for University Hospitals Dorset in accordance with the Constitution. Appointments commenced from 1 October 2021 and the successful candidates are listed in the table on the next page.

Governor expenses

During the period of October 2020 to March 2021, three governors claimed expenses for mileage and related car parking charges to attend meetings or training events both locally and nationally, totalling £74. Wherever possible governors will car share when attending events in the region.

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 chair, 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 was present and in brackets the number of meetings that the governor 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 in the papers for each meeting.

Name	Role	Term of office	Constituency, class or appointing organisation	Attendance
David Moss	Chair			3 (3)
Judith Adda	Governor	2 years	Bournemouth	3 (3)
Richard Allen	Governor	2 years	Christchurch, East Dorset and rest of England	3 (3)
Chris Archibold	Governor	3 years	Christchurch, East Dorset and rest of England	3 (3)
Robert Bufton	Governor	2 years	Poole and rest of Dorset	3 (3)
Marie Cleary	Staff Governor	2 years	Administrative, Clerical and Management	3 (3)
Sharon Collett	Governor	3 years	Bournemouth	3 (3)
Christine Cooney	Governor	3 years	Poole and rest of Dorset	3 (3)
Beryl Ezzard	Appointed Governor	3 years	Dorset Council	3 (3)
Paul Hilliard	Appointed Governor	3 years	Bournemouth, Christchurch and Poole Council	3 (3)
Marjorie Houghton	Governor	3 years	Bournemouth	3 (3)
Cameron Ingham	Staff Governor	3 years	Allied Health Professionals, Scientific and Technical	3 (3)
Carole Light	Governor	2 years	Christchurch, East Dorset and rest of England	3 (3)
Dr Andrew McLeod	Governor	3 years	Poole and rest of Dorset	3 (3)
Keith Mitchell	Governor	3 years	Bournemouth	3 (3)
Connor Morton	Appointed Governor	3 years	UHD Volunteers Group	3 (3)
Sue Parsons	Governor	2 years	Bournemouth	3 (3)
Markus Pettit	Staff Governor	3 years	Estate and Ancillary Services	2 (3)
David Richardson	Appointed Governor	3 years	Dorset CCG	2 (3)
Dr Robin Sadler	Governor	3 years	Christchurch, East Dorset and rest of England	3 (3)
Patricia Scott	Governor	3 years	Poole and rest of Dorset	3 (3)
Diane Smelt	Governor	2 years	Bournemouth	3 (3)
Stephen Tee	Appointed Governor	3 years	Bournemouth University	2 (3)
Kani Trehorn	Staff Governor	3 years	Nursing, Midwifery and Healthcare Assistants	3 (3)
David Triplow	Governor	2 years	Poole and rest of Dorset	3 (3)

Name	Role	Term of office	Constituency, class or appointing organisation	Attendance
Michelle Whitehurst	Governor	2 years	Poole and rest of Dorset	3 (3)
Sandy Wilson	Governor	3 years	Christchurch, East Dorset and rest of England	3 (3)
Vacancy	Staff Governor		Medical and Dental	

Nominations, Remuneration and Evaluation Committee (NREC)

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

Members were the trust chairman and:

- Sharon Collett Public Governor;
- David Triplow Public Governor;
- Sandra Wilson Public Governor;
- Marie Cleary Staff Governor;
- Beryl Ezzard Appointed Governor.

Business for the committee during March 2021:

- a recommendation to the Council of Governors approval of the appointment of the substantive chair and non-executive directors.

In March 2021 on the recommendation of the NREC, the council of governors approved the appointment of the substantive chair, non-executive directors and vice-chair. The Council also approved the appointment of the substantive chief executive.

Nominations, Remuneration and Evaluations Committee Attendance

Name	Constituency	Meetings attended
David Moss	Chair	2 (2)
Marie Cleary	Staff Governor	2 (2)
Sharon Collett	Public Governor	2 (2)
Beryl Ezzard	Appointed Governor	2 (2)
Sandy Wilson	Public Governor	2 (2)
David Triplow	Public Governor	2 (2)

Membership and Engagement

University Hospitals Dorset NHS Foundation Trust has a public constituency and a staff constituency. The public constituency has three classes. These are based on geographical areas that reflect our general, emergency and specialist service catchment areas; local government boundaries; and population numbers. They are:

- Bournemouth;
- Christchurch, East Dorset and Rest of England;
- Poole and Rest of Dorset.

The staff constituency is divided into five classes. They are:

- Medical and Dental;
- Allied Health Professionals, Scientific and Technical;
- Nursing, Midwifery and Healthcare Assistants;
- Administrative, Clerical and Management;
- Estates and Ancillary Services.

Anyone aged 16 and over who lives in England and is not employed by University Hospitals Dorset can become a public member.

At 31 March 2021 the trust had 15,401 public members.

The staff and volunteer members total was over 9,000. All staff and volunteers are members of the Trust automatically unless they choose to opt out.

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

Membership Strategy 2020-2023

Our vision is to build on engagement with members in order to create an active and vibrant membership community, one that has a real voice in shaping the future of the Trust and the services it provides. The strategy sets out three overarching aims:

- To build representative membership that reflects our whole population of Dorset and west Hampshire;
- To improve the quality of mutual engagement and communication so our members are well informed, motivated and engaged;
- To ensure staff members have opportunities to become more actively engaged as members.

Elected governors listen to and represent the opinion of the Trust members on a whole range of issues including the objectives, priorities and strategy within the Trust's forward plan. The governors are given the opportunity to communicate those opinions expressed by members directly or via the council's membership and engagement group.

Appointed governors are able to present the views of their appointing bodies on the objectives, priorities and strategy within the Trust's forward plan directly to the council of governors.

The council reserves time at formal council of governor meetings to pay particular attention to the Trust's forward plan. Those views expressed to the council of governors are communicated to the board of directors via the annual planning processes.

The membership and engagement reference group of the council of governors had one meeting following the formation of the council of governors on 1 January 2021. The group is chaired by a governor and is supported by the company secretary team.

The staff governors are available via email whereby staff members can express views on services and developments within the hospital. This is then anonymously fed back to the chairman and chief executive of the trust.

Members may contact the council of governors through the membership office by telephone **0300 019 8723**, in writing, by email **members.contact@uhd.nhs.uk** or via our website **www.uhd.nhs.uk**. Membership application forms are available on our website.

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.

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	60,628	170,570
Total bills paid within target	55,471	157,216
Percentage of bills paid within target	91.5%	92.2%

NHS payables

	Number	Value
Total bills paid in the period	1,652	19,066
Total bills paid within target	1,484	17,715
Percentage of bills paid within target	89.8%	92.9%

Total

	Number	Value
Total bills paid in the period	62,280	189,635
Total bills paid within target	56,955	174,931
Percentage of bills paid within target	91.4%	92.2%

NHS Improvement's well-led framework

The board of directors has approved a leadership strategy that supports the delivery of the Trust's vision 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. 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. Performance under the leadership strategy will be assessed against these criteria on a quarterly basis, identifying specific areas for attention.

Leadership capacity and capability is supported by management structures within the Trust. A care group model is being established to strengthen 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. 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 reporting period. 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
Chief Executive
9 June 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. It is important to note that the two Trusts had different approaches to managing and investigating complaints prior to the merger and that these are being looked at to streamline approach, policy and procedure. The number of formal complaints received and investigated can be seen below.

Formal complaints received	2020/21 Q3 and 4	2020/21 Q1 and 2		2019/20	
	UHD	RBCH	PH	RBCH	PH
	447	169	75	498	221

The focus of the Patient Advice and Liaison Service is to resolve concerns informally with front line staff. The higher number of formal complaints recorded previously at RBCH reflected a more formal approach to complaint management; and the lower number at PH reflected a greater emphasis on informal resolution. The policy and procedures will standardise the complaints management process across UHD going forwards.

Complaint outcomes

At the close of the complaint investigation the investigation and findings are reviewed and an outcome reached as to whether the complaints is upheld (well-founded), partially upheld or not upheld. The % of complaints upheld and not upheld can be seen in the Table below, together with a comparison against national average.

Outcome of complaints	2020/21 Q3 and 4	2020/21 Q1 and 2			2019/20		
	UHD	RBCH	PH	Nat Ave	RBCH	PH	Nat Ave
Upheld	21%	14%	20%	28%	14%	25%	31%
Partially upheld	29%	33%	39%	35%	37%	36%	33%
Not upheld	50%	53%	41%	37%	49%	39%	36%

Subjects of complaints

Every complaint is assessed at the outset and the key themes extracted. The themes, based on the DOH submission dataset can be seen in the table below; recorded by number and % of total.

Any emerging themes or hotspots are identified and escalated to the Directorate or Care Group triumvirate or to the relevant Director, depending on the seriousness, complexity and/or frequency of complaint theme monitored.

A full summary is reported on a quarterly basis to the Quality Committee.

Complaint Themes	2020/21 Q3 and 4	2020/21 Q1 and 2		2019/20	
		RBCH	PH	RBCH	PH
Clinical treatment	138 (32%)	103 (38%)	61 (30%)	266 (36%)	199 (38%)
Access to treatment	23 (5%)	14 (5%)	1 (0.5%)	41 (6%)	5 (1%)
Admission, discharge, transfers	27 (6%)	13 (5%)	7 (4%)	27 (4%)	20 (4%)
Delays & cancelled appointment	12 (3%)	4 (2%)	3 (2%)	22 (3%)	14 (3%)
Communication	92 (21%)	41 (15%)	37 (18%)	173 (24%)	59 (11%)
Consent	1 (0%)	1 (0.5%)	1 (0.5%)	1 (0%)	1 (0%)

Complaint Themes	2020/21 Q3 and 4	2020/21 Q1 and 2		2019/20	
		RBCH	PH	RBCH	PH
End of life care	3 (0.5%)	0 (0%)	2 (1%)	2 (0.5%)	2 (0.5%)
Facilities	3 (0.5%)	1 (0.5%)	5 (3%)	4 (0.5%)	10 (2%)
Integrated care	2 (0.5%)	0 (0%)	0 (0%)	8 (1%)	0 (0%)
Patient care	97 (23%)	86 (31%)	35 (17%)	179 (24%)	85 (16%)
Mortuary	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Prescribing	3 (0.5%)	0 (0%)	8 (4%)	5 (1%)	21 (4%)
Privacy, dignity & wellbeing	3 (0.5%)	1 (0.5%)	5 (3%)	2 (0.5%)	8 (2%)
Restraint	0 (0%)	0 (0%)	0 (0%)	1 (0%)	0 (0%)
Staffing numbers	0 (0%)	0 (0%)	1 (0.5%)	0 (0%)	0 (0%)
Transport	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Administration	12 (3%)	0 (0%)	15 (8%)	1 (0%)	22 (4%)
Values and Behaviours	13 (3%)	1 (0.5%)	20 (10%)	3 (0.5%)	65 (13%)
Waiting Times	0 (0%)	3 (1%)	0 (0%)	1 (0%)	8 (2%)

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:

You said

"My wife was told she could not accompany me to an outpatient appointment as visiting restrictions meant only the patient could attend. I am deaf and my wife is my interpreter"

We did

"Confirmed that visitor guidance has been updated with specific reference to carers accompanying patients for appointments. All staff have been reminded of this and a note has been added to the patient's electronic patient record to highlight that he is deaf and requires a hearing assistant. We apologised for his experience."

You said

"I was advised that my husband was ready for discharge at 10am, however arrived home at 6pm. The only reason my husband was still in hospital was to wait for his medication. Surely this is not a good use of a hospital bed."

We did

"Ward Sister apologised for delay and absence of communication surrounding patients discharge. Ward Sister confirmed that she was in the process of reinstating Pharmacist and Nursing leads on Ward Rounds, to support fluid communication to prevent medication delays."

You said

"I had an Echocardiogram taken at the Royal Bournemouth Hospital on 12 October 2020 at 11:10. I don't know who requested this, my GP has no record of the request at all. Please can you advise my GP and myself of the results of the Echocardiogram, why the request has not been registered with my GP and why we have received no results."

We did

"Explained that this had occurred due to changes in requesting and reporting investigations within the department. A letter was sent to the patient and his General Practitioner explaining the reason for delay and the results of the echocardiogram.

"Solutions have been identified to address administration issues relating to the requesting and reporting of investigations."

You said

"The referral for fertility treatment was rejected and no explanation provided directly to the patient, as to why."

We did

"A letter template to be developed, explaining to patients why their referral has been rejected."

You said

"Despite being transferred for an urgent MRI scan, it was not completed until the next day. Questions whether this was appropriate and why they were not kept informed of plan of care."

We did

"The pathways for requesting urgent MRI scans in these circumstances differed across our hospitals. Pathways have been reviewed and redeveloped to ensure they are aligned and adhere to national standards."

You said

"Concerns raised about errors in medication prescribing and administration whilst the patient was on the ward."

We did

"The pharmacy team reviewed the stock drugs and added this to the Critical Medicines List. This will be integrated with the electronic prescribing system and any new prescriptions will be flagged to the pharmacy teams to enable the prioritisation of stock to the ward. Staff training will be undertaken."

Referrals to the Parliamentary and Health Service Ombudsman (PHSO)

Complainants who remain dissatisfied with the way the Trust has handled their complaint at local resolution level are able to request an independent review to be undertaken by the Parliamentary and Health Service Ombudsman (PHSO). Complainants are made aware of their right to take their complaint to the PHSO through the Trust information leaflet and in the written response to their complaint.

During 2020/21 Q3 and Q4, the PHSO opened two cases for investigation. In the same time period, the PHSO concluded three investigations into services provided by UHD: one was rejected; one not upheld; and one partially upheld.

Stakeholder relations

2020/2021 has been an exceptional year, due to the pandemic, and as a result there has been exception work with stakeholders to meet the challenges. This has brought the best out of everyone, as the peak over November to March required new ways of working, including daily and weekly calls with tactical and silver command.

In addition, 2020/2021 has seen the development of the Integrated Care System (ICS) as it prepares for the move to statutory status. This has meant closer working with Councils, all NHS Foundation Trusts, NHSE, Dorset CCG and care sector organisations.

A key change since RBCH and PH Foundation Trusts merger on 1st October 2020 has been the work with Bournemouth University. Always a key stakeholder, especially for education and research, the joint strategy being developed will be even wider, including our role as anchor institutions, and our shared agendas, across all four Schools of Bournemouth University, including digital, environment and business schools. This exciting agenda will be developed in 2021/2022 as a joint strategy is agreed.

It has been much harder to engage with the public and representatives, during the pandemic, although the level of public support has been well received and a real tonic for all frontline workers. The use of video conferencing and social media has compensated to some extent.

The list of stakeholders that the Trust has worked with is extensive and will not be given justice to here. In summary despite the turmoil of the pandemic, the organisational change of merger and the usual pressures upon NHS hospitals, 2020/2021 has seen relationships with stakeholders strengthened, setting us up for the future.

Public support throughout the pandemic has been tremendous, and builds upon the already high levels of support, volunteering, donating and appreciation that UHD'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.

Staff and public engagement

University Hospitals Dorset NHS Foundation Trust was launched on 1 October 2020. We held a virtual event for this day with a one hour programme. We had to hold online due to restrictions around the Covid pandemic. In our event we shared details about the benefits of our merger and our future development plans and videos celebrating the day. The day was covered by local media, including the Bournemouth Echo, ITV Meridian and BBC South Today. We have continued since then with our engagement activity to explain the changes happening to healthcare services in Dorset. This has included changes to our 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 Debbie Fleming, our Chief Executive and David Moss, Chair, these briefings became virtual via Teams and provided an additional communication channel for staff to hear about updates. 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 and raise concerns.

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

Website - The Trust's new 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 UHD Facebook page has over 10,891 followers and there are 8,953 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 - Many 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. 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 October 2020 and March 2021 enabled to Trust to communicate with a wide group of stakeholders including the media themselves. Twenty news releases were sent out to the media during this period covering visiting guidance changes, ward moves due to covid and various other updates. This information was also sent over via our other communication channels, including our new UHD website, **www.uhd.nhs.uk**.

Media enquiries: Between October 2020 and March 2021 24 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 over the period 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. We hosted Hugh Pym from BBC National News at the Trust on 8 October 2020 and he reported live at 6pm from outside Royal Bournemouth Hospital. BBC South Today health reporter Alastair Fee also did monthly reports from our hospitals from during this period, covering our response to the pandemic.

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

Major decisions on senior managers' remuneration and terms of service, including salary arrangements for newly appointed directors, changes to individual remuneration arrangements and amendments to salary ranges are made by the Trust's Appointments and Remuneration Committee.

The Appointments and Remuneration Committee reviews the remuneration arrangements for Executive Directors. It is made up of the Chair of the Board of Directors and all the Non-executive Directors of the Board.

The Chief People Officer attends except when his/her own performance and/or salary are discussed. The Chief Executive attends to provide advice on issues concerning the performance of Directors and salary ranges, except when his/her own performance and/or salary are discussed.

The Appointments and Remuneration Committee met on three occasions during the reporting period:

- 28 October 2020: to consider the remuneration proposals for the Chief Officers and recognition of the deputy chief executive director's remuneration
- 30 November 2020: to approve the remuneration proposals for the Chief Officers and to consider the Deputy Chief Executive position
- 24 February 2021: to approve the appointment of the substantive Chief Executive.

Senior Manager's remuneration policy

All Executive Directors are employed on a Trust contract. Directors' remuneration packages do not include any additional components other than salary and entitlement to be part of the standard NHS pension scheme.

Executive Directors' remuneration is managed through a process of objective setting and annual appraisals. Salaries are reviewed by the Trust's appointments and remuneration committee following the executive appraisal cycle. Where a senior manager receives more than £142,500 the trust satisfies itself that this remuneration is reasonable by reference to NHS Providers benchmarking data on Executive Directors' remuneration. The trust does not consult with employees with regard to senior managers' remuneration policy.

Executive salary is determined upon appointment in line with NHS very senior manager guidelines and/or professional pay scales and benchmarking across the NHS. It is reviewed annually by the Trust's Appointments and Remuneration Committee.

All operational practice is in line with employment contracts and aligned to annual plan and delivery.

Service contract obligations

Executive Director contracts do not contain Service obligations which could give rise to or impact on remuneration payments or loss of office.

Payments for loss of office

The Appointments and Remuneration Committee, with regard to HM Treasury guidance, if appropriate, would agree termination payments. Payments for loss of office for executive directors would be made in line with national NHS Policy. The Trust does not have a local policy for payments for loss of office for Directors.

Notice periods for Executive Directors are set in line with national NHS guidelines.

Consideration of general terms

Pay levels are determined by salary surveys conducted by independent consultants and comparisons with salary scales for similar posts in other NHS organisations, and from information provided by NHS Providers.

Senior managers' contracts

All Executive Directors employed during October 2020 to March 2021 were employed on a substantive (permanent) basis. (More details are available in the notes to the table on page 47). More information on the appointment dates for senior managers can be found in the Board of Directors section from page 25.

Directors' substantive contracts carry a six-month notice period.

Benefits policies

Accounting policies for pensions and other retirement benefits are set out in the notes to the accounts and details of senior employees' remuneration.

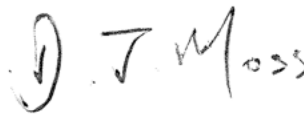
Non-executive directors

Non-Executive Director remuneration is set out in the salary and pensions entitlements' table below; decisions on Non-Executive Director remuneration are made by the Council of Governors, advised by the nominations, remuneration and evaluation committee (see from page 47 for more details).

Off payroll arrangements:

The trust has no off payroll arrangements.

Debbie Fleming
Chief Executive
9 June 2021



David Moss
Chairman
9 June 2021

Senior manager remuneration (audited)

Name	Title (as at 31 March 2021)	Six months ended 31 March 2021				
		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 £5,000) £'000	(bands of £5,000) £'000
Executive Members						
Mrs D Fleming	Chief executive (see note 1)	100 - 105	-	100 - 105	-	100 - 105
Dr A O'Donnell	Chief medical officer (see note 2)	95 - 100	-	95 - 100	-	95 - 100
Mr M Mould	Chief operating officer (see note 3)	90 - 95	-	90 - 95	30 - 35	120 - 125
Mr P Papworth	Chief finance officer (see note 4)	75 - 80	-	75 - 80	60 - 65	135 - 140
Professor P Shobbrook	Chief nursing officer (see note 5)	75 - 80	-	75 - 80	15 - 20	95 - 100
Mrs K Allman	Chief people officer	70 - 75	-	70 - 75	0 - 5	70 - 75
Mr R Renaut	Chief strategy and transformation officer	70 - 75	-	70 - 75	10 - 15	85 - 90
Mr P Gill	Chief informatics and IT officer	65 - 70	-	65 - 70	35 - 40	100 - 105
Non-Executive Members						
Mr D Moss	Chairman	25 - 30	-	25 - 30	Not applicable	25 - 30
Mr P Davé	Non executive director	5 - 10	-	5 - 10	Not applicable	5 - 10
Mr P Green	Non executive director	5 - 10	-	5 - 10	Not applicable	5 - 10
Mrs C Hallett	Non executive director	5 - 10	-	5 - 10	Not applicable	5 - 10
Mr J Lelliott (OBE)	Non executive director	5 - 10	-	5 - 10	Not applicable	5 - 10
Mr S Mount	Non executive director	5 - 10	-	5 - 10	Not applicable	5 - 10
Mr C Shearman	Non executive director	5 - 10	-	5 - 10	Not applicable	5 - 10
Mrs C Tapster	Non executive director	5 - 10	-	5 - 10	Not applicable	5 - 10
Band of highest paid director (Annualised)				200 - 205		
Median Total Remuneration				30,110		
Ratio	Non current trade and other payables excluding non financial liabilities			6.7		

Notes:

1. Mrs D Fleming is not a member of the NHS pension scheme
2. Dr A O'Donnell is not a member of the NHS pension scheme
3. Mr M Mould received back dated pay of £18,527 in relation to his previous role as Deputy Chief Executive of Poole Hospital NHS Foundation Trust up until 30 September 2020
4. Mr P Papworth rejoined the NHS pension scheme on 1st January 2021
5. Professor P Shobbrook was appointed as the Deputy Chief Executive on the 30th November 2020
6. There are 26 Governors (including Staff Governors), of which 3 received expenses during the period amounting to a total of £74
7. Senior Management Remuneration does not include any 'annual related bonus' or long term related bonuses for the period
8. No individual above received any significant benefits in kind for the period
9. No other categories in the proforma single table are relevant to the Trust for the period
10. Of the 16 senior managers in the table above, there were no expenses claims for the period
11. Prior to 1 October 2020, these directors would have been remunerated form the predecessor Trusts. Details of their remuneration is shown in the predecessor accounts for the six month period to 30 September 2020.

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.
- 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 March payments have been annualised and adjustments made for any outliers that would distort the results. Agency costs have been excluded from this calculation.

No employee received remuneration in excess of the highest paid director.

Senior manager pension entitlements

Name	Title (as at 31 March 2021)	Real Increase in Pension at retirement age	Real Increase in Pension Lump Sum at retirement age	Total accrued Pension at retirement age at 31 March 2021	Total accrued Pension Lump Sum at retirement age at 31 March 2021	Cash Equivalent Transfer Value at 1 October 2020	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer-Funded contribution to growth in CETV for the year
		(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	£'000	£'000	£'000	£'000
Mrs D Fleming	Chief executive (see note 1)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dr A O'Donnell	Chief medical officer (See note 2)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mr Mark Mould	Chief operating officer	0 - 2.5	2.5 - 5	55 - 60	125 - 130	1,080	33	1,113	22
Mr P Papworth	Chief finance officer (See note 3)	0 - 2.5	2.5 - 5	15 - 20	40 - 45	190	90	281	85
Professor P Shobbrook	Chief nursing officer	0 - 2.5	0 - 2.5	60 - 65	155 - 160	1,160	21	1,181	10
Mrs K Allman	Chief people officer	0 - 2.5	0 - 2.5	25 - 30	75 - 80	640	8	648	(3)
Mr R Renaut	Chief strategy and transformation officer	0 - 2.5	0 - 2.5	45 - 50	90 - 95	720	14	734	3
Mr P Gill	Chief informatics and IT officer	0 - 2.5	2.5 - 5	45 - 50	100 - 105	852	36	888	26

Notes:

1. Mrs D Fleming is not a member of the NHS pension scheme
2. Dr A O'Donnell is not a member of the NHS pension scheme
3. Mr P Papworth rejoined the NHS pension scheme on 1st January 2021
4. Non Executive Directors do not receive pensionable remuneration, and as such, there are no entries in respect of pensions for Non Executive Directors

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.

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. 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	Chief Executive	1 October 2020	Current	6 months
Karen Allman	Chief People Officer	October 2020	Current	6 months
Peter Gill	Chief informatics and IT Officer	1 October 2020	Current	6 months
Alyson O'Donnell	Chief Medical Officer	1 October 2020	Current	6 months
Pete Papworth	Chief Finance Officer	1 October 2020	Current	6 months
Richard Renaut	Chief Strategy and Transformation Officer	1 October 2020	Current	6 months
Mark Mould	Chief Operating Officer	1 October 2020	Current	6 months
Paula Shobbrook	Chief Nursing Officer	1 October 2020	Current	6 months
Non-Executive Director	Title	Date of appointment	Contract date to	Notice Period
Pankaj Dave	Non-Executive Director	1 October 2020	30 September 2023	1 month
Christine Hallett	Non-Executive Director	October 2020	30 September 2023	1 month
Philip Green (Vice-Chair)	Non-Executive Director	1 October 2020	30 September 2023	1 month
John Lelliott	Non-Executive Director	1 October 2020	30 September 2023	1 month
Stephen Mount	Non-Executive Director	1 October 2020	30 September 2023	1 month
David Moss	Chair	1 October 2020	30 September 2023	1 month
Caroline Tapster (Senior Independent Director)	Non-Executive Director	1 October 2020	30 September 2023	1 month
Cliff Shearman	Non-Executive Director	1 October 2020	30 September 2023	1 month

Remuneration Committee

The appointments and remuneration committee reviews the remuneration arrangements for executive directors. It is made up of the chair of the board of directors and all the non-executive directors of the board. The chief people officer attends except when his/her own performance and/ or salary is discussed. The chief executive attends only to provide advice on issues concerning the performance of executive directors and salary ranges, except when his/her own performance and/or salary is discussed.

The Committee met three times during the reporting period.

Nomination and Remuneration Committee

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).

The Chair 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 Chief Finance Officer on the financial implications of remuneration or other proposals and by the Chief People Officer 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.

The Nomination and Remuneration Committee met on three occasions during the reporting period:

- **28 October 2020:** to consider the remuneration proposals for the Chief Officers and recognition of the deputy chief executive director’s remuneration
- **30 November 2020:** to approve the remuneration proposals for the Chief Officers and to consider the Deputy Chief Executive position
- **24 February 2021:** to approve the appointment of the substantive Chief Executive.

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

This year of unprecedented challenge has brought many successes as we have unified and worked together as 'Team University Hospitals Dorset' throughout the most intensive period of the Covid pandemic while establishing the foundations of our new Trust.

Post-merger integration and Covid Response:

Following merger on 1st October, 2020, our most senior leaders reporting to Chief officers have become established in their new roles as we have engaged with and supported all staff to enable the post-merger implementation plans to be progressed. The focus has been on designing the leadership structure to support delivery of the models of care required and aligning these within the new Care Group structure. This process was severely disrupted as the pandemic resurged and Covid response forced us to pause some of this work. As a merged trust, however, we have been able to realise early benefits of working as one team to address the operational demands this pandemic has presented. Our staff have risen to the challenges, have been flexible and creative in the face of uncertainty and have inspired us every day with their unwavering commitment to excellent patient care across our sites.

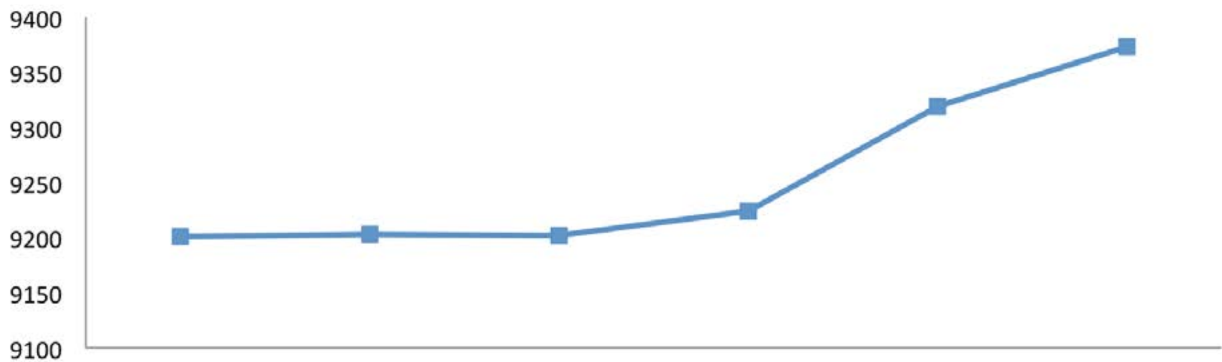
Our people and our people-support teams and services have all had to change approach at extremely short notice. Services to our staff in the pandemic have included HR helplines, dealing with a massive influx of temporary staff, retraining people, daily communications, fast tracked Occupational Health services, risk assessment for all staff, an increased volume and range of health and wellbeing options including psychological support, support to shielding staff, recording new and essential data, changes to policy and working practices and latterly a massive exercise to support staff vaccination.

Integration planning has continued and consultations for the next tiers of leadership across the hospitals and in corporate functions have been taking place throughout the spring in accordance with the Trust's Organisational Change policy, with staff and their representatives being given an opportunity to comment and make alternative suggestions. UHD remain committed to working closely with staff side as we progress with post-merger implementation plans and service changes.

Staff numbers:

The headcount of substantive staff employed in October 2020 was 9,201 and this figure stands at 9,373 heads as at March 2021.

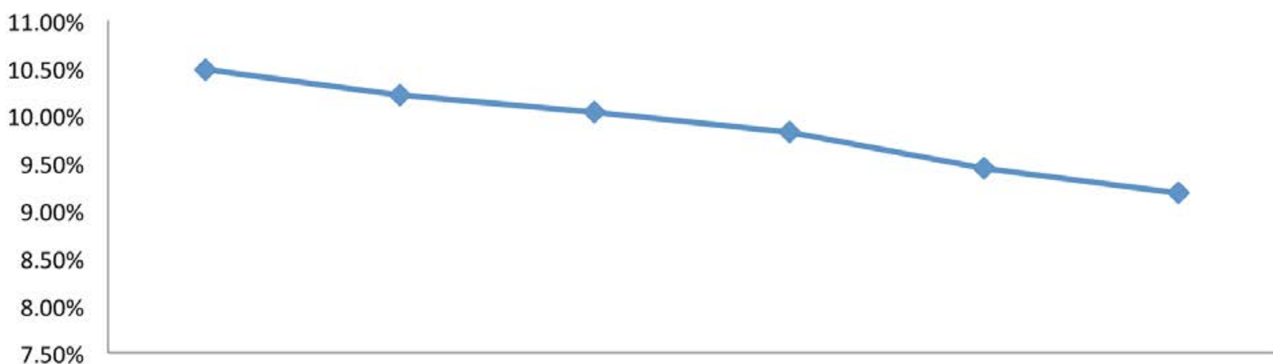
Substantive staff headcount trend:



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Headcount	9201	9203	9202	9224	9319	9373

Turnover % across UHD has been lower than in a normal year for the legacy Trusts which is probably due to Covid uncertainty and the recruitment of additional permanent staff has been steady. We have however had an influx of temporary support in this time and have relied on our temporary workforce on all sites who have made a significant contribution in this period.

Permanent staff turnover rate (headcount)

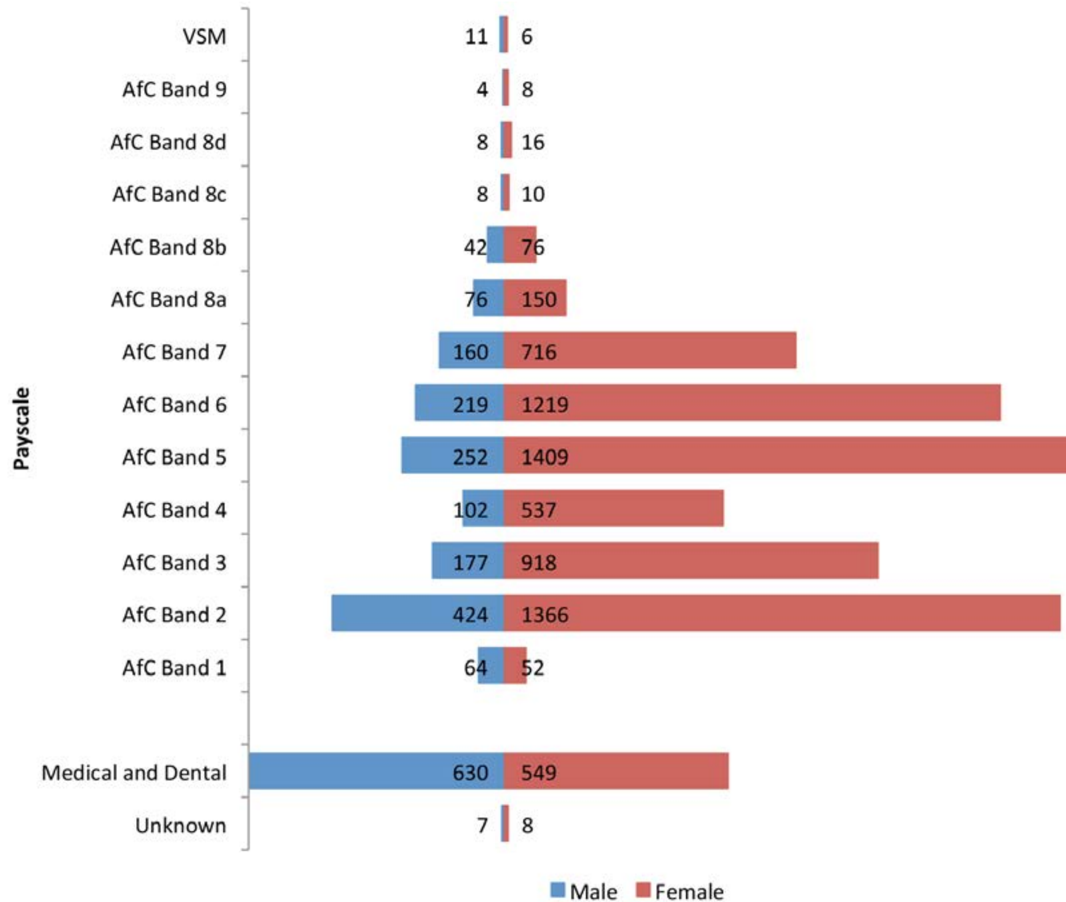


	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total	10.48%	10.21%	10.03%	9.82%	9.44%	9.18%

We have been working to align our workforce systems in order to bring all information under one process. This has required us to join the payrolls by April and merge rostering systems in the same timeframe.

The gender split by band is shown below.

Workforce tree (headcount) with gender split
as at 31/03/2021

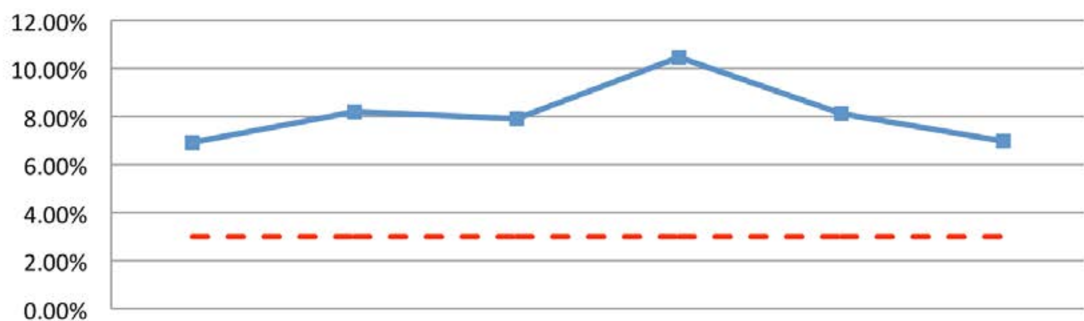


Information on gender pay gap can be found on the Cabinet Office website:
Https://gender-pay.service.gov.uk

Sickness absence data

Sickness absence levels have been significantly higher than normal this year due to the impact of Covid, shielding and self-isolation.

In month sickness absence rate (FTE)



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
In Month Absence Rate	6.92%	8.20%	7.91%	10.46%	8.12%	6.97%
Target	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.

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. During the period the Trust incurred one non-compulsory agreed exit package costing £1,763.

Risk management

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

Staff policies

The Trust People Policy task and finish group, which includes representatives from Human Resources and Staff Side, continues to work through People Policies for UHD which are subsequently sent to the UHD Staff Partnership Forum for ratification.

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.

Expenditure on consultancy

During the period the Trust reported total consultancy expenditure of £120,365.

Occupational health

The occupational health service is staffed by a team of clinical staff and registered nurses, all with occupational health experience and a team of administrative staff. Medical expertise is provided by occupational health physicians. Amongst the services offered by occupational health are pre-employment screening, individual casework such as return to work assessments and management referrals, support for 'needlestick' (hypodermic needle) injuries, workplace assessments, Control Of Substances Hazardous to Health (COSHH) assessments and surveillance. In addition the team has expertise MSK assessment and physiotherapy treatment as well as wellbeing support and guidance.

The Trade Union (Facility Time Publication Requirements) Regulations 2019

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
45	38.93

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%	24
1-50%	17
51%-99%	2
100%	2

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	£55,514
Provide the total pay bill	£215,890.013
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.44%

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: (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

Communicating the values of our UHD Culture and listening to the voices of UHD staff members through a range of staff engagement activities are core elements of the UHD Organisational Development plan. During this period, the Culture Champions presented to the Board recommendations for the new UHD Values, which resulted from staff views about what the UHD values should be. These were agreed and successfully launched during the Values week in February 2021. Since our legacy trusts came together to form UHD we have continued to support the embedding of our Values which has included partnership work with our Staff Network Groups' leads. This has led to further engagement in areas which matter for example in the development of a new values based appraisal process, enabling our Values to be placed at the heart of all we do.

NHS National Staff Survey

The annual NHS staff survey enables all staff to give their views confidentially about a number of areas which matter. Work commenced on 1 September with our fieldwork conducted in October and November, when the survey is open for eligible staff to complete. Although we were required to conduct a separate survey at each legacy trust, we secured a report which includes all staff views and results across our three hospital sites to use at a local level.

The combined UHD response rate to the 2020 survey amongst eligible Trust staff was 35.7% (2019: PHT = 42.6%, RBCH - 47.8%), reflecting the national reduction in responses during the pandemic. The results are grouped into 10 Themes with scores based on survey question responses relating to that Theme.

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

	Theme	2020		2019			2018		
		UHD Trust	Benchmark group (top score)	RBCH	Poole	Benchmark group (top score)	RBCH	Poole	Benchmark group (top score)
1	Equality, diversity and inclusion	9.1	9.5	9.2	9.2	9.4	9.2	9.3	9.6
2	Health and wellbeing	6.24	6.9	6.4	6.0	6.7	6.4	6.1	6.7
3	Immediate managers	7.0	7.3	7.4	7.0	7.4	7.3	6.8	7.3
4	Morale	6.55	6.9	6.7	6.3	6.7	6.6	6.3	6.7
5	Quality of care	7.63	8.1	7.8	7.4	8.1	7.7	7.3	8.1
6	Safe environment - bullying and harassment	8.22	8.7	8.3	8.0	8.5	8.4	8.2	8.5
7	Safe environment - Violence	9.47	9.8	9.4	9.4	9.6	9.5	9.4	9.6
8	Safety culture	6.88	7.4	7.2	6.7	7.2	7.2	6.7	7.2
9	Staff Engagement	7.31	7.6	7.5	7.2	7.5	7.5	7.1	7.6
10	Team working	6.77	7.1	7.2	6.7	7.2	7.1	6.6	7.1

Future priorities and targets

The combined UHD Management Report outlining our results across our UHD sites has provided a useful overview of the results which were gathered during the pandemic and immediately following merger. We are pleased that even within the organisational and national context of the 2020 survey our scores for staff engagement remain high and well above our benchmark group.
Work has begun to prepare for the 2021 Staff Survey and as the Trust implements the new organisational structure, we will be aligning teams to ensure the 2021 survey is as reflective of the new organisation as possible.

The trust has taken action to evidence that staff views given within the survey have been listened to. UHD has plans in place to extend the ability to raise concerns safely, through the Freedom to Speak Up ambassadors, and the UHD OD plan will support the trust to develop compassionate, inclusive leaders with exceptional management skills and the ability to build effective teams going forward. This will help us to address the reduction in scores around bullying and harassment, and violence at work.

We will also focus on some of the questions where we have lower scores around staff interaction with both their immediate manager and senior managers. We are conducting a listening exercise using our new Culture Champions to discover how staff want to be recognised for living our new values and what other support they need after the pandemic to feel valued.

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

Our trust survey action plan also includes supporting team leaders to build effective teams as well as continuing to embed the new Trust values and behaviours to help managers to have good development conversations. Looking ahead, we are developing a plan for improved survey response rates in 2021, so that we have a greater understanding of how it feels to work at UHD.

Equality, Diversity and Inclusion

Our strategy for equality, diversity and inclusion sets out our approach to equality and diversity, both as an employer and as a healthcare organisation. This was developed in partnership with staff inclusion networks, community partners and patient representatives. The strategy sets out our equality objectives with measurable outcomes and goals, aligned to our organisational vision, mission and values. It also contains how we will deliver on key guidance and statutory requirements relating to equality and diversity, including the NHS Constitution, the Equality Act 2010 and having due regard for the Public Sector Equality Duty and Care Quality Commission's (CQC) domains of safe, effective, caring, responsive, and well led. We will be working alongside our partners in the Dorset Integrated Care System (ICS) to ensure our objectives are aligned and are representative of the needs of our workforce and local community.

Our equality, diversity and inclusion group (EDIG) governance structure has been reviewed and updated with new Terms of Reference and membership. The group is chaired by Pete Papworth (Director of Finance) and Christine Hallett (Non-Executive Director) who have responsibility for inequalities in their portfolio.

The group includes representatives from across the organisation, including staff network leads, Governors and patient representatives. Its purpose is to provide the governance and assurance to the Workforce Strategy Committee and Trust Board on compliance with statutes and national

standards and makes recommendations on specific interventions.

Inclusion Networks

Our staff networks have continued to flourish and during the Covid-19 pandemic. We are extremely proud of their progress in developing key working relationships internally and externally to support the workforce during the most challenging time in the NHS has ever seen. Their work has been pivotal in staff engagement and ensuring issues and concerns are heard at a senior level.

- Hosting cultural awareness and information sessions
- Developing covid risk assessments in partnership with HR colleagues
- Deaf awareness training and support, highlighting issues with mask wearing and supporting the development nationally of clear mask alternatives
- EU Settled Status support and advice for colleagues and the organisation
- Workshops on Allyship, Black Lives Matter, Pronouns, Gender identity
- Drop in events: safe spaces and listening events
- Representing UHD at regional and national network events, internal NHS and external (Filipino Nurses Association, Cavendish Coalition, Disability network, Stonewall) sharing good practice and learning
- Developing their key working relationships within the trust to offer expert advice and guidance on policies and process reviews
- Being active partners in promoting engagement with the cultural change programme and Trust values development
- Representing their membership at EDIG

Reverse Mentoring

Our first Reverse Mentoring programme began in October 2019 and was extended through the pandemic in 2020 due to the challenges the Mentors and Mentees faced during this period. Our programme was supported by an external facilitator, Professor Stacy Johnson from Nottingham University. The pilot programme has achieved its aims at an individual relationship level with increased confidence and profile of Mentors. The next cohort will extend across the new larger organisation and include all underrepresented groups.

In Summary

The Covid Pandemic has shone a spotlight on health inequalities that have impacted significantly on our workforce and patients. EDIG will take forward this momentum to the benefit of all, remaining vigilant and responsive.

NHS Foundation Trust Code of Governance

University Hospitals Dorset 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. Details of compliance or an explanation are provided in this report.

Debbie Fleming
Chief Executive
9 June 2021

Annual Governance Statement (1 October 2020 to 31 March 2021)

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 University Hospitals Dorset 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 University Hospitals Dorset NHS Foundation Trust for the period 1 October 2020 - 31 March 2021 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 Chief Nursing Officer is responsible for supervising the management of the services regulated by the Care Quality Commission.

The Chief Medical Officer and Chief Nursing Officer 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. The Trust's organisational development programme supports an open culture, and this is encapsulated in the Trust values which have been developed by our staff and agreed by the Trust Board. As Chief Executive, I sponsor the role of the Freedom to Speak Up Guardian who 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.

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. The board assurance framework is reviewed six 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.

High risks (those with a risk rating of 12-25), including any changes to these, are reviewed by the Board of Directors and Quality Committee at each meeting. The work of the Board of Directors and its committees is supported by a range of specialist committees including the Trust Management Group, the Quality Governance Group, which focuses on clinical quality and risk management, the Clinical Audit and Effectiveness Group and directorate clinical governance and risk management groups. 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, National Patient and Staff surveys, Care Quality Commission Insight 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, mortality reviews and incidents are discussed locally at directorate clinical governance groups. 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 Governance Group and the Quality Committee. Each of the other committees of the Board of Directors reviews the high risks relevant to areas within its scope of responsibility and in accordance with the Trust risk appetite statement. The Quality 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 Quality Committee and is verified annually 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 board assurance framework process. The development of the board assurance framework 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 board assurance framework. 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 board assurance framework, 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 board assurance framework 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 Quality Committee, Finance and Performance Committee, Workforce Strategy Committee, Transformation Committee, Sustainability Committee, Infection Prevention and Control Group, Medicines Governance Group, Information Governance Steering Group, Quality Governance Group and Health & Safety Group. 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 and Issues Forms 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 Quality Committee, which meets monthly. The Quality Committee is chaired by a non-executive director and membership includes representation from the Board of Directors and the Council of Governors. The Quality Governance Group also reviews all new clinical risks monthly ensuring escalation to the Quality Committee as appropriate. The full board assurance framework 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 mitigating actions, controls, or risk rating.

The most significant risk still 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 daily in line with national, professional, and local guidance to ensure staff and patient safety and maintain high standards of patient care.

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 to ensure integration of clinical pathways and services.

As well as operational risks, 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.

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 October 2020 - 31 March 2021) was a period of unprecedented challenge for the hospital workforce, facing the stark risks and realities of Covid-19 and following the long-anticipated merger.

In this period the Trust ensured that risk mitigation decisions were taken in the context of fairness and consistency across all three hospitals with policy and practice becoming even further aligned. The challenges of supporting the Trusts workforce to stay safe and well to do their essential work through Covid-19 at the same time as progressing with post-transaction implementation were significant. 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 almost 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 year 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 Strategy 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 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 order to support the professional leadership of these staff groups a new post of Associate Director for Allied Health Professionals and Healthcare Scientists, has been appointed. 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, with direct links between quality matrices and staffing being made; this was evidenced through Directorate and Care Group quality and risk reports to the Quality Governance Group and Quality Committee. 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, including skill mix changes had a Quality Impact Assessment review undertaken.

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 6 month extension to achieve compliance with the 2019/20 DSP Toolkit by 30th 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 100% on mandatory requirements, and was graded as "Standards Met". Consequently, the DSP Toolkit for 2020/21 was also delayed, but has now been released with a deadline of 30 June 2021.

During 2020/21 to 30th September, 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. The Trust was not formally inspected or rated during the period 1 October 2020 - 31 March 2021.

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. Both predecessor Trusts received positive use of resources assessments (RBCHFT rated as 'outstanding' in 2018; PHFT rated as 'good' in September 2019) as part of the CQC well-led rating.

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 and the Board of Directors.

During the period from 1 October 2020 to 31 March 2021, 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 October 2020 - 31 March 2021.

The production processes have mirrored those used for all quality assessments and aspects of these have been regularly checked and validated throughout the year as part of routine governance processes. Data management largely handled by the Trust's Information Department, Quality and 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 Quality 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
Chief Executive
9 June 2021

Consolidated financial statements

for the six months ended **31 March 2021**

Contents

The Foundation Trust 3

Foreword to the accounts 4

Accounting Officer's Statement 5

Auditors' Report 6

Primary Statements
- Statement of Comprehensive Income 11
- Statement of Financial Position 12
- Statement of Changes in Taxpayers' Equity 13
- Statement of Cash Flows 14

Notes to the accounts
Note 1: Accounting policies 15
Note 2: Operating segments 30
Note 3: Income generation activities 30
Note 4: Operating income 31
Note 5: Private patient monitoring 32
Note 6: Mandatory and non-mandatory income from activities 33
Note 7: Operating expenses 33
Note 8: Operating leases 35
Note 9: Staff costs and numbers 35
Note 10: Retirements due to ill-health 36
Note 11: The Late Payment of Commercial Debts (Interest) Act 1998 37
Note 12: Investment revenue 37
Note 13: Finance costs 38
Note 14: Intangible assets, property, plant and equipment 39
Note 15: Impairment of property, plant and equipment 40
Note 16: Capital commitments 40
Note 17: Inventories 40
Note 18: Trade and other receivables 41
Note 19: Cash and cash equivalents 43
Note 20: Trade and other payables 43
Note 21: Other liabilities 44
Note 22: Borrowings 44
Note 23: Finance lease obligations 45
Note 24: Provisions for liabilities and charges 46
Note 25: Related party transactions 47
Note 26: Post Statement of Financial Position events 48
Note 27: Financial risk management 48
Note 28: Financial instruments 50
Note 29: Intra-government and NHS balances 52
Note 30: Losses and special payments 52
Note 31: Judgements and estimations 53
Note 32: Senior manager remuneration 53
Note 33: Senior manager pension entitlements 53
Note 34: Charitable Fund Reserve 53
Note 35: Gains/(losses) from transfers by absorption 54

The Foundation Trust

NHS Foundation Trust Code:	**R0D**	
Registered Office:	**Poole Hospital** Longfleet Road Poole BH15 2JB	
Executive Directors:	**Mrs D Fleming**	Chief Executive Officer
	Mrs P Shobbrook	Chief Nursing Officer
	Mr P Papworth	Chief Finance Officer
	Mr M Mould	Chief Operating Officer
	Mrs K Allman	Chief People Officer
	Dr A O'Donnell	Chief Medical Officer
	Mr P Gill	Chief Informatics and IT Officer
	Mr R Renaut	Chief Strategy and Transformation Officer
Non-Executive Directors:	**Mr D Moss**	Chairman
	Mrs C Tapster CBE	Non-Executive Director
	Mr P Green	Non-Executive Director
	Mr P Davé	Non-Executive Director
	Mr C Shearman	Non-Executive Director
	Mr S Mount	Non-Executive Director
	Mr J Lelliott OBE	Non-Executive Director
	Ms C Hallett	Non-Executive Director
Trust Secretary:	**Mrs F Ritchie**	
Banker:	**Barclays PLC** London	
Solicitor:	**DAC Beachcroft LLP** Winchester	
Internal Auditor:	**BDO LLP** Southampton	
External Auditor:	**KMPG LLP** Southampton	

Foreword to the accounts

These accounts for the six months ended 31 March 2021 for University Hospitals Dorset 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
Chief Executive Officer
9 June 2021

Accounting Officer's Statement

Statement of the Chief Executive's responsibilities as the Accounting Officer of University Hospitals Dorset 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 University Hospitals Dorset NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Dorset NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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, Chief Executive Officer
9 June 2021

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of University Hospitals Dorset NHS Foundation Trust ("the Trust") for the period 1 October 2020 to 31 March 2021 which comprise the Group and Trust Consolidated Statement of Comprehensive Income, Statements of Financial Position, Group and Trust Consolidated Statement of Changes in Taxpayers Equity and 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 and Trust's affairs as at 31 March 2021 and of the Group and Trusts income and expenditure for the period then ended; and
- 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.

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.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Group and Trust's business model and analysed how those risks might affect the Group and Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group and Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Group and Trust will continue in operation.

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 and inspection of policy documentation as to the Group and Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group and Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Group and Trust'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 the current financial regime, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk of incentive for revenue to be manipulated into the wrong period around the year end.

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 period-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

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 unexpected account pairings, unexpected users, seldom users, unusual cash transactions and journals containing specific comments.
- Evaluating the business purpose of significant unusual transactions.
- Assessing significant estimates for bias.
- Inspecting transactions in the period following 31 March 2021 to verify revenue had been recognised in the correct accounting period.
- Inspecting transactions in the period following 31 March 2021 to verify expenditure had been recognised in the correct accounting period.
- Evaluating accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements

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 other management (as required by auditing standards), and from inspection of the Group and Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Group and Trust 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 and Trust 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 and Trust 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.

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; and
- in our opinion the other information included in the Annual Report for the period 1 October 2020 to 31 March 2021 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.

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 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 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 its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.

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

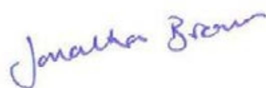
We have nothing to report in these respects.

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 University Hospitals Dorset Hospitals NHS Foundation Trust for the period 1 October 2020 to 31 March 2021 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
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

22 June 2021

Statement of Comprehensive Income

		Group	Trust
	Notes	**2020/21**	**2020/21**
		£'000	**£'000**
Operating income from continuing operations	4	**356,603**	**355,087**
Operating expenses of continuing operations	7	**(353,845)**	**(350,237)**
OPERATING (DEFICIT) / SURPLUS		**2,758**	**4,850**
FINANCE COSTS			
Finance income: Interest receivable	12	**6**	**1**
Finance expense: Interest payable	13	**(368)**	**(368)**
Finance expense: Unwinding of discount on provisions	24	**7**	**7**
Public Dividend Capital: Dividends payable		**(3,526)**	**(3,526)**
Loss on disposal of assets	14	**(10)**	**(10)**
Movement in fair value of investment property and other investments		**279**	**0**
(Loss) profit from Joint Venture		**305**	**305**
Gains/(losses) from transfers by absorption	35	**354,654**	**339,430**
(DEFICIT) / SURPLUS FOR THE PERIOD		**354,126**	**340,710**
Other comprehensive income			
Impairment (chargeable to revaluation reserve)		**(5,517)**	**(5,517)**
TOTAL COMPREHENSIVE (EXPENSE) FOR THE PERIOD		**348,609**	**335,193**

The notes on pages 15 to 54 form part of these accounts.

Note a. 2020/21 Control Total	**2020/21**
	£'000
Deficit for the period (above)	**340,710**
Add back impairment	**2,189**
Adjust (gains) / losses on transfers by absorption	**(339,430)**
Less donated capital/fixed asset disposal adjustment	**(3,497)**
Control total surplus/(deficit) including PSF, FRF, MRET and Top-up	**(28)**
Add BHT surplus	**172**
Control total deficit	**144**
Agreed control total deficit	**0**
Performance against control total	**144**

Statement of Financial Position

		Group		Trust	
	Notes	**31 March 2021**	Transfer by Absorption 1 October 2020	**31 March 2021**	Transfer by Absorption 1 October 2020
		£'000	£'000	**£'000**	£'000
Non-current assets					
Intangible assets	14	**16,774**	15,254	**16,774**	15,254
Property, plant and equipment	14	**362,110**	324,848	**361,882**	324,675
Investments in LLP Joint Venture	12.2	**2,141**	1,815	**2,141**	1,815
Other Investments	12.3	**6,320**	4,544	**0**	0
Trade and other receivables	18	**1,418**	2,307	**1,418**	2,307
Total non-current assets		**388,764**	348,768	**382,216**	344,051
Current assets					
Inventories	17	**7,090**	7,155	**7,090**	7,155
Trade and other receivables	18	**18,828**	21,041	**19,740**	21,076
Other financial assets	12.4	**47**	47	**0**	0
Cash and cash equivalents	19	**109,537**	128,056	**97,534**	115,547
Total current assets		**135,502**	156,298	**124,365**	143,778
Current liabilities					
Trade and other payables	20	**(99,999)**	(86,180)	**(95,728)**	(84,165)
Borrowings	22	**(3,808)**	(3,478)	**(3,808)**	(3,478)
Provisions	24	**(3,165)**	(966)	**(3,165)**	(966)
Other liabilities	21	**(5,199)**	(29,818)	**(5,199)**	(29,818)
Total current liabilities		**(112,171)**	(120,441)	**(107,900)**	(118,427)
Total assets less current liabilities		**412,094**	384,625	**398,680**	369,402
Non-current liabilities					
Borrowings	22	**(27,409)**	(25,059)	**(27,409)**	(25,059)
Provisions	24	**(4,028)**	(4,044)	**(4,028)**	(4,044)
Other liabilities	21	**(853)**	(869)	**(853)**	(869)
Total non-current liabilities		**(32,289)**	(29,971)	**(32,289)**	(29,972)
Total assets employed:		**379,805**	354,654	**366,390**	339,430
Taxpayers' equity					
Public Dividend Capital		**243,243**	212,047	**243,243**	212,047
Revaluation reserve		**86,025**	92,058	**86,025**	92,058
Income and expenditure reserve		**37,121**	35,325	**37,121**	35,325
BHT Charitable Fund Reserve		**1,713**	1,541	**0**	0
NHS Charitable Fund Reserve	34	**11,702**	13,683	**0**	0
Total Taxpayers' equity:		**379,805**	354,654	**366,390**	339,430

The notes on pages 15 to 54 form part of these accounts. Comparative information is at 1 October 2020 in line with GAM requirements.

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 9 June 2021 and signed on its behalf by:

Mrs D Fleming, Chief Executive Officer, 9 June 2021

Statement of Changes in Taxpayers' Equity

	Trust				BHT Charity	PH Charity	BH Charity	Group
	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Trust Reserves	Other Reserves	Charitable Fund Reserve	Charitable Fund Reserve	Total Reserves
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current Period								
Taxpayers' Equity at 1 October 2020	**212,047**	**92,058**	**35,325**	**339,430**	**1,541**	**3,906**	**9,777**	**354,654**
Surplus/(deficit) for the period	0	0	1,280	1,280	172	284	(2,265)	**(529)**
Transfers between reserves	0	(516)	516	0	0	0	0	**0**
Impairment losses on property, plant and equipment	0	(5,517)	0	(5,517)	0	0	0	**(5,517)**
Public Dividend Capital received	31,196	0	0	31,196	0	0	0	**31,196**
Taxpayers' Equity at 31 March 2021	**243,243**	**86,025**	**37,121**	**366,389**	**1,713**	**4,190**	**7,512**	**379,805**

The notes on pages 15 to 54 form part of these accounts.

Statement of Cash Flows

	Notes	Group		Trust	
		2020/21		2020/21	
		£'000		£'000	
Cash flows from operating activities					
Operating surplus from continuing operations			**2,758**		**4,850**
Operating surplus of discontinued operations			**0**		**0**
Operating surplus/(Deficit)			**2,758**		**4,850**
Non-cash income and expense					
Depreciation and amortisation	14	**9,100**		**9,154**	
Impairments / Reversal of Impairments	14	**2,189**		**2,189**	
Non-cash donations/grants credited to income		**(4,089)**		**(4,271)**	
(Increase)/Decrease in Trade and Other Receivables		**4,042**		**2,514**	
(Increase)/Decrease in Inventories		**65**		**65**	
Increase/(Decrease) in Trade and Other Payables		**11,663**		**11,902**	
Increase/(Decrease) in Other Liabilities		**(24,635)**		**(24,635)**	
(Increase)/Decrease in provisions		**2,190**		**2,190**	
NHS Charitable Funds - net adjustments for working capital movements and non-cash transactions		**1,666**		**0**	
			2,192		**(891)**
Net cash flow from operations			**4,949**		**3,959**
Cash flow from investing activities					
Interest received		**1**		**1**	
Purchase of intangible assets		**(2,421)**		**(2,421)**	
Purchase of property, plant and equipment		**(44,470)**		**(44,470)**	
Cash donations to purchase capital assets		**2,739**		**2,739**	
NHS Charitable funds - net cash flow from investing activities		**(1,497)**		**0**	
Net cash flow from investing activities			**(45,649)**		**(44,152)**
Cash flow from financing activities					
Public dividend capital received		**31,196**		**31,196**	
Loans received and repaid		**(1,598)**		**(1,598)**	
Capital element of finance lease rental payments		**(112)**		**(112)**	
Interest paid on ITFF loan		**(363)**		**(363)**	
Interest element of finance leases	13	**(3)**		**(3)**	
PDC dividend paid		**(6,939)**		**(6,939)**	
			22,181		**22,182**
Net increase in cash and cash equivalents			**(18,519)**		**(18,012)**
Cash and cash equivalents transferred by absorption			**128,056**		**115,547**
Cash and cash equivalents at end of period	19		**109,537**		**97,534**

The notes on pages 15 to 54 form part of these accounts.

Notes to the accounts

1 Accounting policies

1.1 Accounting policies and other information

These are the first published accounts for the new Foundation Trust and cover the period from 1 Ocotber 2020 to 31 March 2021.

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.

Going concern

After making enquiries, the directors have a reasonable expectation that the services provided by the Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

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 governement implemetation date 1st April 2022, 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. Further information is provided in Note 1.22
- 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.

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 and Poole Hospital NHS Foundation Trust Charitable Fund

The NHS Foundation Trust is the corporate trustee of both The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund (Charity Registration number 1057366) and Poole Hospital NHS Foundation Trust Charitable Fund (Charity Registration number 1058808). The Foundation Trust has assessed its relationship to the respective charitable funds and determined them to be subsidiaries 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 funds and has the ability to affect those returns and other benefits through its power over the funds.

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

Some 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 together 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 commercial transaction resulting in a significant non recurrent profit which is reflected within these accounts.

Christchurch Fairmile Village Limited Liability Partnership: Company Registration Number OC395417

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 year end, the Trust accrues income relating to performance obligations satisfied in that year. 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 main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

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 obligtion 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 year, 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, fundraising 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 31 March 2021, is based on valuation data as at 31 March 2019, updated to 31 March 2021 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 year;
- 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 year 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 desktop valuation (excluding Assets Under Construction/ Work In Progress) was undertaken as at 31 March 2021. 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 at the top of the next 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 31 March 2021, 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:

- Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met;
- 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 years to the extent that the condition has not yet been met.

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

1.6 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 24 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 year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) 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 year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.14 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

After making enquiries, the directors have a reasonable expectation that the services provided by the Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

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 and the Poole Hospital NHS Foundation Trust Charitable Fund 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 31 March 2021. 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 year-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 1.27% 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 period ended 31 March 2021 is as follows:

	Group	Trust
	Healthcare 2020/21	**Healthcare 2020/21**
	£'000	**£'000**
Segment revenue	**356,603**	**355,087**
Patient and other income	**356,603**	**355,087**

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.

4 Operating income

4.1 Income from patient related activities

	Group	Trust
	Continuing Operations 2020/21	**Continuing Operations 2020/21**
	£'000	**£'000**
Foundation Trusts and NHS Trusts	**3,496**	**3,496**
Clinical Commissioning Groups	**251,232**	**251,232**
NHS England	**64,162**	**64,162**
Non NHS:		
- Private Patients	**1,424**	**1,051**
- Overseas Patients (non-reciprocal)	**73**	**73**
- NHS Injury Scheme Income	**301**	**301**
- Other	**25**	**25**
	320,713	**320,341**

The Trust recognises a notional income amount of £8,869,000 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 22.43% doubtful debt provision is included in expenditure, which represents expected recovery rates.

4.2 Other operating income

	Group	Trust
	Continuing Operations 2020/21	**Continuing Operations 2020/21**
	£'000	**£'000**
Research and development	**1,185**	**1,185**
Education and training	**10,639**	**10,639**
NHS Charities - capital acquisitions (donated assets)	**28**	**210**
NHS Charities - contributions to expenditure	**5,292**	**5,292**
Cash grants for the purchase of capital assets - received from other bodies	**2,739**	**2,739**
Received from other bodies: Other charitable and other contributions to expenditure	**1,460**	**1,460**
Donated equipment from DHSC for COVID response (non-cash)	**1,322**	**1,322**
NHS Charitable Funds: Incoming Resources excluding investment income	**1,507**	**0**
Non-patient care services to other bodies	**5,633**	**5,633**
Education and training - notional income from apprenticeship fund	**500**	**500**
Top up	**3,641**	**3,641**
Other:		
- NHS drug sales	**20**	**20**
- Car parking	**373**	**373**
- Catering services	**653**	**653**
- Miscellaneous other	**361**	**543**
Income from operating leases	**536**	**536**
	35,889	**34,746**
Total	**356,603**	**355,087**

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
	2020/21	2020/21
	£'000	£'000
Commissioner requested services	**331,352**	**330,980**
Non Commissioner requested services	**25,250**	**24,107**
	356,603	**355,087**

7 Operating expenses

	Group	Trust
	Continuing Operations	Continuing Operations
	2020/21	2020/21
	£'000	£'000
Purchase of healthcare from NHS and DHSC bodies	**3,032**	**3,032**
Purchase of healthcare from non-NHS and non-DHSC bodies	**4,159**	**4,159**
Purchase of social care	**72**	**72**
Employee Expenses - Executive directors	**795**	**795**
Employee Expenses - Non-executive directors	**86**	**86**
Employee Expenses - Staff	**223,162**	**223,162**
Employee Expenses - Notional employer contributions paid by NHSE (6.3%)	**8,869**	**8,869**
Supplies and services - clinical (excluding drug costs)	**26,146**	**26,146**
Supplies and services - clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**5,292**	**5,292**
Supplies and services - general	**5,805**	**5,548**
Establishment	**2,421**	**2,421**
Research and development (excluding Employee Expenses)	**157**	**157**
Education and training - non-staff costs	**1,432**	**1,432**
Education and training - notional expenditure funded from apprenticeship fund	**500**	**500**
Transport (staff travel)	**179**	**179**
Transport (patient transport services)	**290**	**290**
Premises - Rates	**1,494**	**1,494**
Premises	**10,518**	**10,518**
Movement in credit loss allowance: all other receivables & investments	**658**	**658**

	Group	Trust
	Continuing Operations	**Continuing Operations**
	2020/21	**2020/21**
	£'000	**£'000**
Movement in credit loss allowance: contract receivables/assets	**276**	**276**
Provisions arising / released in year	**499**	**499**
Change in provisions discount rate(s)	**(42)**	**(42)**
Inventories written down	**(10)**	**(10)**
Drug costs	**32,015**	**32,015**
Depreciation on property, plant and equipment	**7,998**	**8,052**
Amortisation on intangible assets	**1,102**	**1,102**
Impairments net of (reversals)	**2,189**	**2,189**
Audit fees:		
External audit services - financial statement audit	**92**	**92**
External audit services - audit-related assurance services	**5**	**5**
External audit services - charitable fund accounts	**2**	**0**
Internal Audit and Counter Fraud	**95**	**95**
Clinical negligence premium	**6,976**	**6,976**
Legal fees	**289**	**289**
Consultancy costs	**120**	**120**
Insurance	**243**	**243**
Other services	**1,286**	**1,286**
Charges to operating expenditure for off-SoFP PFI scheme	**71**	**71**
Losses, ex gratia and special payments	**29**	**29**
NHS Charitable funds: Other resources expended (balance not analysed above)	**3,404**	**0**
Other	**2,139**	**2,140**
Total	**353,845**	**350,237**

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

8 Operating leases

8.1 Operating leases, as lessee

The Trust currently holds no operating leases as a lessee.

8.2 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 year is disclosed as.

	Group/Trust
	2020/21
	£'000
Operating Leases	**536**
The future aggregate minimum lease payments under non-cancellable operating leases are as follows:	
No later than one year	**997**
Between 1 and 5 years	**644**
Over 5 years	**2,588**
Total	**4,229**

9 Staff costs and numbers

9.1 Staff costs

	Group	Trust
	2020/21	2020/21
	£'000	£'000
Salaries and wages	**179,487**	**179,487**
Social security costs	**16,549**	**16,549**
Apprenticeship Levy	**847**	**847**
Employer's contributions to NHS Pensions	**20,436**	**20,436**
Pension Cost - other contributions	**8,869**	**8,869**
Agency/contract staff	**7,727**	**7,727**
Total	**233,915**	**233,915**

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

9.2 Average number of persons employed

	2020/21
	£'000
Medical and dental	1,135
Administration and estates	1,214
Healthcare assistants and other support staff	23
Nursing, midwifery and health visiting staff	4,216
Scientific, therapeutic and technical staff	2,224
Healthcare science staff	117
Other	38
Total	**8,967**
Of which:	
Permanent	8,021
Other	946
Total	**8,967**

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

9.3 Staff exit packages

	Group	Trust
	2020/21	2020/21
	£'000	**£'000**
Less than £10,000	**1**	**2**
£10,001 - £25,000	**0**	**0**
£25,001 - £50,000	**0**	**0**
£50,001 - £100,000	**0**	**0**
£100,001 - £150,000	**0**	**0**
£150,001 - £200,000	**0**	**0**
Over £ 200,000	**0**	**0**
Total	**1**	**2**

The above exit package was in relation to 1 non-compulsory agreed departure.

10 Retirements due to ill-health

There were two early retirements from the Foundation Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £29,000. Any costs of ill-health retirements are borne by the NHS Pensions Agency.

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

There were minimal payments of interest for commercial debts.

12 Investment revenue

12.1 Investment revenue

	Group	Trust
	31 March 2021	**31 March 2021**
	£'000	**£'000**
Interest on bank accounts	**1**	**1**
NHS charitable funds: investment income	**5**	**0**
Total	**6**	**1**

12.2 Investment in joint venture

	Group / Trust
	31 March 2021
	£'000
Opening Balance as at 1 October 2020	**0**
Transfer by Absorption 1 October 2020	**1,815**
Share of profit / (loss)	**326**
Disbursements / dividends received	**0**
Closing Balance	**2,141**

University Hospitals Dorset NHS Foundation Trust holds a 25% 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.

12.3 Charity investments

	Group	Trust
	31 March 2021	**31 March 2021**
	£'000	**£'000**
Opening Balance as at 1 October 2020	**0**	**0**
Transfer by Absorption 1 October 2020	**4,544**	**0**
Acquisitions	**1,497**	**0**
Movement in fair value	**279**	**0**
Closing Balance	**6,320**	**0**

12.4 Other financial assets

	Group		Trust	
	31 March 2021	Transfer by Absorption 1 October 2020	**31 March 2021**	Transfer by Absorption 1 October 2020
	£'000	£'000	**£'000**	£'000
Fixed Deposit (less than one year)	**47**	47	**0**	0
Total	**47**	47	**0**	0

13 Finance costs

	Group / Trust
	31 March 2021
	£'000
Loans from the Independent Trust Financing Facility	**364**
Finance leases	**3**
Unwinding of discount on provisions	**(7)**
Other finance costs	**1**
Total	**361**

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	NHS Charitable fund assets	Non Current Assets	Less Non-Trust Assets	Trust Assets
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross cost at 1 October 2020	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer by Absorption 1 October 2020	28,869	34,358	211,818	5,845	26,373	117,888	393	33,437	1,633	168	460,783	1,387	459,396
Additions	2,421	3,375	92	33	25,316	13,939	0	1,027	733	0	46,937	0	46,937
Additions - leased	0	0	4,390	0	0	0	0	0	0	0	4,390	0	4,390
Additions - donations of physical assets (non-cash)	0	0	37	0	0	172	0	0	0	0	210	0	210
Additions - assets purchased from cash donations/grants	0	0	0	0	0	1,322	0	0	0	0	1,322	0	1,322
Additions - assets purchased from cash donations/grants		0	0	0	2,739	0	0	0	0		2,739	0	2,739
Impairments - Operating expenses	0	0	(2,365)	0	0	0	0	0	0	0	(2,365)	0	(2,365)
Impairments - Revaluation reserve	0	0	(5,517)	0	0	0	0	0	0	0	(5,517)	0	(5,517)
Reversal of impairments credited to operating expenses	0	0	145	31	0	0	0	0	0	0	176	0	176
Reclassifications	201	0	2,707	0	(4,231)	1,126	0	1	196		0	0	0
Disposals	0	0	0	0	0	(1,494)	0	0	0	0	(1,494)	0	(1,494)
Cost or valuation at 31 March 2021	**31,492**	**37,733**	**211,307**	**5,908**	**50,197**	**132,954**	**393**	**34,465**	**2,562**	**168**	**507,181**	**1,387**	**505,794**
Accumulated depreciation at 1 October 2020	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer by Absorption 1 October 2020	13,615	0	0	0	0	81,574	280	23,997	1,214	0	120,680	1,213	119,466
Provided during the period	1,102	0	3,726	79	0	2,987	15	1,152	37	2	9,100	(54)	9,154
Disposals	0	0	0	0	0	(1,484)	0	0	0	0	(1,484)	0	(1,484)
Accumulated depreciation at 31 March 2021	**14,717**	-	3,726	79	-	**83,076**	**296**	**25,149**	**1,251**	**2**	**128,296**	**1,159**	**127,137**
Net book value													
Owned	16,774	37,733	198,960	5,829	50,197	48,330	97	9,317	1,311	166	368,715	228	368,487
Finance lease	0	0	4,390	0	0	226	0	0	0	0	4,616	0	4,616
Donated	0	0	4,232	0	0	0	0	0	0	0	4,232	0	4,232
Owned - equipment donated from DHSC and NHSE for COVID response		0	0	0	0	1,322	0	0	0	0	1,322		1,322
NBV total at 31 March 2021	**16,774**	**37,733**	**207,582**	**5,829**	**50,197**	**49,878**	**97**	**9,317**	**1,311**	**166**	**378,885**	**228**	**378,657**
The asset classifications are as follows:													
- Protected	0	35,976	204,992	5,829	50,197	49,878	97	9,317	1,311	0	357,597	0	357,597
- Unprotected	16,774	1,757	2,590	0	0	0	0	0	0	166	21,287	228	21,059
Total	**16,774**	**37,733**	**207,582**	**5,829**	**50,197**	**49,878**	**97**	**9,317**	**1,311**	**166**	**378,885**	**228**	**378,657**

The Foundation Trust leases various medical equipment/ IT under non-cancellable finance lease agreements. The lease terms are between five and seven years.
A desktop valuation of the Trusts land and buidlings was undertaken on 31 March 2021 by independent valuers Cushman & Wakefield Debenham Tie Leung Ltd.

15 Impairment of property, plant and equipment

	Group	Trust
	31 March 2021	**31 March 2021**
	£'000	**£'000**
Changes in market price (as advised by the Trust's external valuer)	**2,189**	**2,189**
Total	**2,189**	**2,189**

16 Capital commitments

	Group
	31 March 2021
	£'000
Property, plant and equipment	**64,453**
Intangible assets	**1,943**
Total	**66,396**

17 Inventories

	Group	
	31 March 2021	Transfer by Absorption 1 October 2020
	£'000	£'000
Drugs	**2,715**	2,731
Consumables	**4,374**	4,100
Other	**0**	324
Total	**7,090**	7,155

17.1 Inventories recognised in expenses

	Group
	31 March 2021
	£'000
Inventories recognised as an expense in the period	**20,181**
Notional consumables donated for COVID response	**0**
Write-down of inventories (including losses)	**(10)**
Total	**20,171**

18 Trade and other receivables

18.1 Amounts falling due within one year:

	Group		Trust	
	31 March 2021	Transfer by Absorption 1 October 2020	**31 March 2021**	Transfer by Absorption 1 October 2020
	£'000	£'000	**£'000**	£'000
Contract receivables (IFRS 15): invoiced	**8,339**	8,705	**8,339**	8,705
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**7,920**	8,321	**8,837**	7,795
Allowance for impaired contract receivables / assets	**(470)**	(1,270)	**(470)**	(1,270)
Allowance for impaired other receivables	**(2,573)**	(1,939)	**(2,573)**	(1,939)
Prepayments (revenue) [non-PFI]	**5,317**	6,258	**5,317**	6,258
PDC dividend receivable	**290**	0	**290**	0
VAT receivable	**0**	514	**0**	514
Other receivables	**0**	111	**0**	1,013
NHS charitable funds: receivables	**5**	341	**0**	0
Total	**18,828**	21,041	**19,740**	21,077
Amounts falling due over one year:				
Clinician pension tax provision reimbursement funding from NHSE	**1,418**	1,418	**1,418**	1,418
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**0**	1,137	**0**	1,137
Allowance for impaired contract receivables / assets	**0**	(248)	**0**	(248)
Total	**20,246**	23,348	**21,158**	23,384

The provision for impairment of receivables relates to specific receivables.

18.2 Allowances for credit losses (doubtful debts)

	Group	Trust
	31 March 2021	31 March 2021
	£'000	£'000
Contract receivables and contract assets:		
Opening Balance as at 1 October 2020	**0**	**0**
Transfer by Absorption 1 October 2020	**1,518**	**1,518**
New allowances arising	**1,079**	**1,079**
Changes in the calculation of existing allowances	**24**	**24**
Reversals of allowances (where receivable is collected in-year)	**(121)**	**(121)**
Utilisation of allowances (where receivable is written off)	**(1,325)**	**(1,325)**
Foreign exchange and other changes	**(705)**	**(705)**
At 31 March 2021	**470**	**470**
All other receivables:		
Opening Balance as at 1 October 2020	**0**	**0**
Transfer by Absorption 1 October 2020	**1,939**	**1,939**
New allowances arising	**0**	**0**
Changes in the calculation of existing allowances	**563**	**563**
Utilisation of allowances (where receivable is written off)	**(610)**	**(610)**
Changes arising following modification of contractual cash flows	**(24)**	**(24)**
Transfer to FT upon authorisation	**705**	**705**
At 31 March 2021	**2,573**	**2,573**

19 Cash and cash equivalents

	Group	Trust
	31 March 2021	**31 March 2021**
	£'000	**£'000**
Opening Balance as at 1 October 2020	**0**	**0**
Transfer by Absorption 1 October 2020	**128,056**	**115,546**
Net movement in period	**(18,519)**	**(18,013)**
Balance at 31 March	**109,537**	**97,534**
Made up of:		
Cash at commercial banks and in hand	**13,432**	**1,429**
Cash with the Government Banking Service	**96,105**	**96,105**
Cash and cash equivalents	**109,537**	**97,534**

The patient monies amount held on trust was £3,000 which is not included in the above figures.

20 Trade and other payables

	Group		Trust	
	31 March 2021	Transfer by Absorption 1 October 2020	**31 March 2021**	Transfer by Absorption 1 October 2020
	£'000	£'000	**£'000**	£'000
Amounts falling due within one year:				
Trade payables	**26,991**	37,975	**26,093**	36,838
Capital payables (including capital accruals)	**8,593**	5,808	**8,593**	5,808
Accruals (revenue costs only)	**48,965**	28,738	**48,965**	28,738
Annual leave accrual	**2,500**	0	**2,500**	0
Receipts in advance (including payments on account)	**243**	298	**243**	298
Social security costs	**5,022**	5,571	**5,022**	5,571
VAT payables	**105**	109	**105**	109
Other taxes payable	**4,103**	3,405	**4,103**	3,405
Other payables	**105**	275	**105**	275
PDC dividend payable	**0**	3,123	**0**	3,123
NHS Charitable funds: trade and other payables	**3,373**	877	**0**	0
Total	**99,999**	86,180	**95,728**	84,166

This includes outstanding pension contributions at 31 March 2021 of £5,710,000.

21 Other liabilities

	Group		Trust	
	31 March 2021	Transfer by Absorption 1 October 2020	**31 March 2021**	Transfer by Absorption 1 October 2020
	£'000	£'000	**£'000**	£'000
Amounts falling due within one year:				
Receipts in advance - Heart club	**15**	30	**15**	30
Receipts in advance - Commissioner contracts	**0**	51,142	**0**	51,142
Receipts in advance - Grants	**1,802**	1,724	**1,802**	1,724
Receipts in advance - Other	**3,382**	(23,077)	**3,382**	(23,077)
Total	**5,199**	29,818	**5,199**	29,818
Amounts falling due over one year:				
Receipts in advance - Heart club	**853**	869	**853**	869
Total	**6,052**	30,687	**6,052**	30,687

22 Borrowings

	Group / Trust	
	31 March 2021	Transfer by Absorption 1 October 2020
	£'000	£'000
Finance lease liabilities		
- Current	**394**	194
- Non current	**4,225**	147
Total	**4,619**	341
Independent Trust Financing Facility (ITFF) Loan		
- Current	**3,026**	3,025
- Non current	**23,184**	24,653
Total	**26,210**	27,678
Independent Trust Financing Facility (ITFF) Loan		
- Current	**388**	259
- Non current	**0**	259
Total	**388**	518

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.

Additionally, at the end of March 2021, the Foundation Trust entered into a 20 year finance lease to aquire additional off-site office space. The cost of the lease was £4,390,000.

	Group / Trust	
	31 March 2021	Transfer by Absorption 1 October 2020
	£'000	£'000
Amounts payable under finance leases		
Within one year	**394**	196
Between one and five years	**1,089**	150
After five years	**3,750**	0
Less future finance charges	**(614)**	(6)
Total	**4,619**	340

24 Provisions for liabilities and charges

	Group / Trust				
	£'000	£'000	£'000	£'000	**£'000**
	Early Retirement	Injury Benefit	Other Legal claims	Other	**Total**
Opening Balance as at 1 October 2020	0	0	0	0	**0**
Transfer by Absorption 1 October 2020	313	1,779	257	2,660	**5,009**
Change in the discount rate	0	(42)	0	0	**(42)**
Arising during the period	49	91	92	2,347	**2,578**
Utilised during the period - cash	(34)	(58)	0	0	**(92)**
Reversed unused	0	(17)	(170)	(67)	**(254)**
Unwinding of discount	(1)	(6)	0	0	**(7)**
At 31 March 2021	328	1,746	179	4,940	**7,193**
Expected timing of cashflows:					
Within one year	58	33	0	3,074	**3,165**
Between one and five years	242	1,542	169	448	**2,401**
After five years	28	171	10	1,418	**1,627**
	328	1,746	179	4,940	**7,193**

Current and non current

Early Retirement and Injury Benefit

The early retirement and injury benefit provisions relate to the estimated actuarial pension liabilities in respect of staff who retired due to sickness, injury or redundancy prior to 2004.

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 2021 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.

£96,595,000 is included in the provisions of NHS Resolution at 31 March 2021 in respect of clinical negligence liabilities of the Foundation Trust.

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	235,604	474	0	1,409
NHS West Hampshire CCG	15,703	0	1	0
NHS Bath and North East Somerset, Swindon and Wiltshire CCG	600	0	0	0
Health Education England	10,683	0	47	0
NHS Resolution (formerly NHS Litigation Authority)	0	6,976	0	0
NHS England - Core	8,403	0	2,225	0
NHS England - South West RO	47,223	0	225	0
Dorset County Hospital	1,176	721	209	390
Dorset Healthcare Unversity NHS FT	5,109	1,090	1,865	490
University Hospitals Southampton NHS FT	2,321	551	1,220	823
NHS Pension Scheme	0	29,305	0	5,710
Other transactions less than £500,000	29,783	314,728	13,036	96,376
	356,603	353,845	18,828	105,198

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	0	17,396	0	5,710
HM Revenue and Customs	0	29,305	0	4,207
National Insurance Fund	0	16,549	0	5,022
	0	63,250	0	14,939

26 Post statement of financial position events

There were no post statement of financial position events.

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 year. This helps to identify any significant NHS receivable queries.

Provision for doubtful debts

The Foundation Trust reviews non NHS receivables as at 31 March 2021 and as a result of this review, has provided £1,978,000 in relation to doubtful debts. A further £91,000 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 £561,000. 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 year and continues to have a surplus on the retained earnings reserve. In addition, the Foundation Trust has a cash balance of £99,620,000. As such, the Trust is a minimal risk to its creditors.

28 Financial instruments

28.1 Financial assets

	Group				Trust	
		31 March 2021		Transfer by Absorption 1 October 2020	**31 March 2021**	Transfer by Absorption 1 October 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	**14,634**	**0**	15,553	0	**14,634**	15,553
Other Investments	**5,317**	**0**	3,843	0	**5,317**	3,843
Cash and cash equivalents at bank and in hand	**99,623**	**0**	117,608	0	**99,623**	117,608
NHS charitable funds: financial assets as at 31 March	**9,966**	**6,320**	10,787	4,590	**(821)**	0
Total	**129,540**	**6,320**	147,791	4,590	**118,753**	137,003
Assets held in £ sterling		**135,860**		152,381	**118,753**	137,003

28.2 Financial liabilities

	Group		Trust	
	31 March 2021	Transfer by Absorption 1 October 2020	**31 March 2021**	Transfer by Absorption 1 October 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	**26,210**	27,678	**26,210**	27,678
Other borrowings excluding finance lease and PFI liabilities	**388**	0	**388**	0
Obligations under finance leases	**4,619**	341	**4,619**	341
NHS trade and other payables excluding non-financial liabilities	**3,999**	25,048	**3,999**	25,048
Non-NHS trade and other payables excluding non-financial liabilities	**82,111**	47,582	**82,111**	47,582
Provisions under contract	**7,193**	4,203	**7,193**	4,203
NHS Charitable funds: financial liabilities as at 31 March	**3,373**	876	**0**	0
Total	**127,893**	105,728	**124,520**	104,852
Liabilities held in £ sterling	**127,893**	105,728	**124,520**	104,852

28.3 Financial assets / liabilities - fair values

	Group		Trust	
	31 March 2021		**31 March 2021**	
	£'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	**6,320**	**6,320**	**0**	**0**
Total	**6,320**	**6,320**	**0**	**0**
Financial liabilities				
Non-current trade and other payables excluding non-financial liabilities	**853**	**853**	**853**	**853**
Provisions under contract	**7,193**	**7,193**	**7,193**	**7,193**
Total	**8,046**	**8,046**	**8,046**	**8,046**

29 Intra-Government and NHS balances

	Group / Trust	
	31 March 2021	
	Receivables: amounts falling due within one year	Payables: amounts falling due within one year
	£'000	£'000
Providers	**3,507**	**2,526**
NHS and Department of Health	**3,019**	**1,473**
Local Government	**2,896**	**0**
Central Government	**11**	**14,939**
Total	**9,432**	**18,938**

30 Losses and special payments

	Group / Trust	
	31 March 2021	
	Number	**£'000**
Losses		
Losses of cash due to:		
Damage to buildings, property and equipment	**6**	**194**
Total losses	**6**	**194**
Special Payments		
Ex gratia payments in respect of:		
Loss of personal effects	**24**	**15**
Miscellaneous other	**7**	**24**
Total special payments	**31**	**39**
Total	**37**	**233**

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 31 March 2021. Estimates are based on the Foundation Trust's current understanding of the actual committed expenditure.
- An estimate is made for depreciation and amortisation of £9.1 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 £5.5 million has been charged to the revaluation reserve, with a further £2.2 million included within operating expenses. This reflects the desktop valuation of Trust land and buildings carried out by the Trusts external valuers.

32 Senior manager remuneration

Directors' remuneration totalled £881,000 for the six months ended 31 March 2021. Full details are provided within the Remuneration Report.

33 Senior manager pension entitlements

There were benefits accruing to six 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:

	31 March 2021	Transfer by Absorption 1 October 2020
	£'000	£'000
Restricted funds	**9,950**	11,464
Unrestricted funds	**1,752**	2,219
Total	**11,702**	13,683

35 Gains/(losses) from transfers by absorption

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 and Poole Hospital NHS Foundation Trust were dissolved, the closing assets and liabilities of the respective Trusts were transferred by absorption to University Hospitals Dorset NHS Foundation Trust.

						Group	Trust
	RBCH NHS FT	PGH NHS FT	BHT Charity	PH Charity	BH Charity	Transfer by Absorption 1 October 2020	Transfer by Absorption 1 October 2020
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non-current assets	195,772	148,279	6	168	4,544	348,769	344,051
Current assets	101,415	42,363	2,672	9,707	226	156,383	143,778
Current liabilities	(70,093)	(48,334)	(1,137)	(98)	(864)	(120,526)	(118,427)
Non-current liabilities	(16,831)	(13,141)	0	0	0	(29,972)	(29,972)
Total assets employed	**210,263**	**129,167**	**1,541**	**9,777**	**3,906**	**354,654**	**339,430**
Public Dividend Capital	85,466	126,581	0	0	0	212,047	212,047
Revaluation reserve	66,216	25,842	0	0	0	92,058	92,058
Income and Expenditure Reverse	58,581	(23,256)	0	0	0	35,325	35,325
BHT Charitable Fund Reserve	0	0	1,541	0	0	1,541	0
NHS Charitable Fund Reserve	0	0	0	9,777	3,906	13,683	0
Total Taxpayers' equity	**210,263**	**129,167**	**1,541**	**9,777**	**3,906**	**354,654**	**339,430**

University Hospitals Dorset NHS Foundation Trust

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

Poole Hospital
Longfleet Road, Poole, BH15 2JB

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**