NHS

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

Annual Report and Accounts 2019/20

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

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Foreword

From our Joint Chief Executive and Chairman

Welcome to our annual report for 2019/20. This year, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) and Poole Hospital NHS Foundation Trust (PHT) have worked even more closely together, in anticipation of the formal merger of our two organisations. This merger has been a very long time coming, but we know it will bring huge benefits for patients and staff alike. Our new organisation will be better placed to recruit and retain staff, and make best use of resources - and most importantly, by bringing services together, we can improve the quality of care provided for our patients.

Much has been achieved this year as we have moved forwards with our plans for merger, culminating in December 2019 with approval from our two Boards of Directors to establish a new Shadow Interim Board. The Shadow Interim Board is responsible for overseeing the creation of the new merged organisation and taking forwards our future strategy. As such, this represented a significant milestone on our merger journey. Decisions taken by the Shadow Interim Board still require ratification by the two existing Boards, who will retain their current statutory duties and responsibilities right up until the establishment of the new organisation.

During this year, we said goodbye to Mark Orchard, Director of Finance for Poole Hospital and took the opportunity to appoint our new Interim Joint Director of Finance. Pete Papworth, previously Director of Finance at RBCH, was appointed to this role from 1 October 2019. Throughout the year, with the support of our regulators and permission from the Competition and Markets Authority (CMA), we have made a number of joint appointments - most importantly, our four clinical transformation leads who have worked on bringing our teams together and to develop joined up workforce plans across our two organisations. Initially, the four priority services were emergency medicine, trauma & orthopaedics, theatres & anaesthesia and older people's medicine. The list was then expanded to include stroke, maternity and cardiac services, along with our business support services, such as HR, finance and governance. This work is still on-going as a key focus within our wider merger programme

Throughout the year, we continued taking forwards our plans to achieve University Hospital status. A few months ago, we were able to announce that this had been successful, and that the name of our new merged organisation will be University Hospitals Dorset NHS Foundation Trust. This reflects the extremely close working relationship that the two hospitals and the university have enjoyed over many years. Becoming established from the outset as a University Hospital reflects the on-going commitment of the new organisation to learning, innovation and research.

We had originally hoped to complete the merger by July 2020, but it was agreed that this would not be possible in light of the outbreak of the Covid-19 pandemic. With the situation improving, we are delighted that our sector regulator NHS Improvement (NHSI) has now formally agreed that we might progress our plans to merge on 1 October 2020. This follows on from the approval by the Competition and Markets Authority (CMA) earlier this year. Clearly, this is excellent news as we know that we can serve local people better as the larger, more resilient University Hospitals Dorset NHS Foundation Trust.

Meanwhile, the core business of both Trusts of course continues to be the delivery of safe, high quality care for our patients. Looking back on 2019/20, the pressure across our hospitals never really let off. We went from one busy winter, to a much busier June and July – with more patients attending our Emergency Departments than anticipated for the time of year. The Dorset health and social care system was also extremely busy over the festive season in 2019, and this continued into the new year.

Both the Royal Bournemouth Hospital and Poole Hospital experienced significant pressures throughout the winter period. For example, in December 2019, both Emergency Departments saw almost 10% more patients compared to December 2018. Similar pressures were experienced in respect of our planned work, with both Trusts receiving more referrals and struggling to maintain short waiting times in the face of increasing demand. As a consequence, maintaining performance standards was extremely challenging.

The situation was not helped by some of the NHS pension changes, which resulted in fewer clinicians being able to work the extra sessions needed to reduce waiting times. This national issue has largely been resolved from April 2020, but the backlog built up in 2019/20 was very significant and will obviously now be further impacted by Covid-19. This will be one of the priorities for us to address as we try to get back to "business as usual", working closely with Dorset County Hospital in the west to ensure that acute services are provided in a consistent and equitable way.

More positively, excellent progress has been made throughout the year on reducing the number of "stranded patients" - that is, those with a length of stay greater than seven days. This is very good news for individuals in that it reduces the risk of harm and a loss of independence; it is also good news for the hospital, in that it frees up resources and allows us to treat sicker patients. The situation then improved further in an unprecedented way when Covid-19 required all partners to work together to discharge those patients who no longer needed acute care in hospitals from early March.

Our work on stranded patients was made possible thanks to our close working relationship with our partners in the Dorset Integrated Care System (ICS). Much work has been undertaken as part of the Integrated Community and Primary Care Services Programme to reduce admissions and speed up discharge. This includes working very closely with colleagues in Dorset HealthCare, who provide ongoing community-based care for patients who are medically ready to leave our acute hospitals, along with support from the Dorset Commissioning Group (CCG). We have particularly valued connecting with our two newly formed local councils this year, BCP Council and Dorset Council. We are very fortunate to have such a strong ICS in Dorset, with positive relationships amongst partners and a shared commitment to serving local people well.

Another important priority for 2019/20 has been taking forwards our exciting capital development programme. We originally submitted the Outline Business Care relating to our capital plans at the end of March 2019 and since then, we have been working to develop our Full Business Case. Our plans for the building work at Poole Hospital and The Royal Bournemouth Hospital were submitted to the BCP Council during the course of the year for approval, and we are hopeful that these will be approved in the very near future. These plans of course represent a once-in-a-lifetime opportunity to secure £147m Treasury investment for the NHS in Dorset, to develop our two hospital sites.

The developments at The Royal Bournemouth Hospital will enable the establishment of a new Maternity Unit, a new Children's Unit, an expanded Emergency Department and expanded Critical Care facilities – all of which will be vitally important in meeting the future health needs of the local population. The need for a new Maternity Unit is very well understood in the area, with various plans for a new facility having been submitted on several occasions in the past. However, now that funding has been set aside at a national level to support this development, a new purpose-built Maternity Unit - with adjacent purpose-built Children's facilities - can become a reality for local people.

There is also an urgent need to expand and update the operating theatres at Poole Hospital, which will enable patients to have far better care, in modern, purpose-built facilities. Our current day case theatres are lacking space, privacy and dignity for patients, essentially reflecting the fact they were designed and built in the 1960s. If planning permission is granted, it will enable us to open new, state of the art theatres, which will allow us to expand capacity, and enable patients from across the area to gain swifter access to essential surgery. The development of the Poole site also includes creating a new 24/7 Urgent Treatment Centre, expected to treat between 50,000 and 60,000 patients each year.

In June last year, we had the opportunity to share our building plans with our local stakeholders, including MPs, local councillors, staff and the public at two open events, held at each of our hospitals. These were both very well attended and were part of a wider schedule of public engagement in all our development plans. We also held an open event for stakeholders at the Christchurch Hospital in January 2020, when we were able to share our exciting plans for the redevelopment of that site. Working with Macmillan Caring Locally, the joint proposals are for a new 20 bed Macmillan hospice, 160 affordable extra care homes for over 55s and additional NHS services, including outpatient physiotherapy.

The plans for developing all three of our hospitals are aimed at changing the way we deliver care in order to deliver improved outcomes for our patients, so it is important that we share these widely to explain these benefits widely.

Overall, 2019 was a very important year for all our hospitals. In July, we were able to share our plans with the Rt Honourable Matt Hancock, Secretary of State for Health and Social Care, when he visited to find out more about our transformation plans. We were joined by senior leaders from across the Dorset system and had the opportunity to not only update him on our plans, but also to highlight some of the challenges that we face together in meeting the needs of the local population.

Later in the year, Poole Hospital celebrated its 50th anniversary, and the opening of the hospital Her Majesty, The Queen in 1969. We planted a tree outside the Dolphin Restaurant, with a plaque to mark the occasion and special anniversary cakes were distributed to all wards and departments. We also opened our new main entrance to the hospital and were joined by local guests of honour, Harry and Sandra Redknapp. This was a truly happy occasion!

In the autumn, our two trusts held public Open Days - one for Poole Hospital in September and one for RBCH in October. Both events were hugely successful, giving our staff an opportunity to showcase their work, and the public the opportunity to “go behind the scenes” at an NHS hospital. We are hugely grateful to our staff and our wonderful volunteers, who worked so hard at these events to make them so informative and enjoyable.

Of course, our hospitals are really all about our people, and it is the high calibre and commitment of all our staff that makes our two Trusts such great places to receive care and to work. In everything we do, we engage closely with our staff, ensuring that their views are taken into account in all our decision-making. Between July and September, Poole Hospital completed a Listening Exercise with its staff, known as “The Story of Now”. Eighteen “People Champions” gathered views from nearly 400 staff, across a wide range of roles and services, then presented this to the Board via the Workforce and Organisation Development Committee in October. This was a very important piece of work, which supplemented the feedback received from our annual and quarterly Staff Surveys.

The Change Champions within The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) completed a similar exercise earlier in the year and the output of this work was also fed back to the Board. Both sets of feedback were shared with senior leaders from across the two organisation at the Joint Leadership Forum in December, as part of a very interactive development session. This work has been extremely important in developing a shared understanding as to what is important to staff across all our sites, and has been incorporated into the development plan for our new, merged organisation.

We also established/developed several staff support networks during the course of the year, with one of the most important in 2019 being our EU staff support network, given the on-going Brexit negotiations that hung heavily over the whole year and were so very unsettling for many of our staff. Around 10% of our workforce comes from the EU, representing a large number of our people. Our EU staff are very highly valued within both Trusts, as indeed are all our overseas staff. Many support events were arrange for them in the year and our teams provided practical assistance with applications to the EU Settlement Scheme, including subsidising any fees involved.

Overall, both Trusts performed well in the annual staff survey, with the results for The Royal Bournemouth and Christchurch Hospitals being one of the strongest set of results in the country. The two Trusts have of course worked closely together to develop a joint action plan, which again forms part of the organisation development plan for the new organisation, and is being taken forwards in a collaborative way, ahead of formal merger.

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

So, for a whole range of reasons, 2019/20 has been an extremely challenging year! Throughout this time, we have been fortunate to have the support of our staff, governors, volunteers, fundraisers and members. Their hard work and dedication makes our hospitals the places that they are today and we sincerely thank them for everything that they do. With their on-going support, we shall bring our two trusts together in a way that not only fulfils our ambitious development plans, but also ensures that the new University Hospitals NHS Foundation Trust is even more highly regarded within our local community.

There is a lot to be done now in 2020/21 as our Trusts move on to complete the formal merger transaction process, against the backdrop of the Covid-19 pandemic. In the midst of all the distress that the pandemic has clearly caused, we are very proud of our staff and leaders, and all that they have achieved. We are determined to come through this together, stronger as a consequence of all we have collectively learned.

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

In closing, we should like to thank all those who have been involved in the work to take forwards the merger, and to thank everyone who has been supporting the Trusts for your on-going commitment throughout 2019/20. We look forward to continuing making great progress together as we commence a new era in 2020/21.

Debbie Fleming, Interim Joint Chief Executive, 24 June 2020

David Moss, Joint Chairman, 24 June 2020

About our Trust

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

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

We provide a wide range of hospital and community-based care to a population of 550,000 based in the Dorset, New Forest and south Wiltshire areas. This number rises over the summer months due to the influx of tourists which sees over 1 million visitors to our region annually. For some of our specialist services, we also serve the wider population across the whole of Dorset of nearly 1 million. Our business model is based on the national Payment by Results methodology for managing expenditure within the context of agreed contracts with commissioners. 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 2019/20 we employed 4,870 members of staff, both clinical and non-clinical

Over the year we cared for and treated the following patients:

Number of outpatient attendances (follow ups): 239,850
Number of new outpatient attendances: 106,559
Number of admissions 113,392:
Number of attendances to Emergency Department Type 1 and 2: 96,999
Number of attendances to Emergency Department – Urgent Treatment Centre: 10,014

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 palliative care (the Macmillan Unit).

How we are run

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

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

The Council of Governors, which represents around 10,000 members, is made up of members of the public, staff and appointed governors. They ensure members’ views are heard and are fed back to our Board of Directors, and members of the public are kept up to date with developments within the hospitals.

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 hospitals and the Board also works closely with the Council of Governors.

The Trust is organised under three clinical care groups and a number of departments providing support services. We also work closely with a range of key health and social care partners to develop and deliver our services, such as clinical commissioning groups and social services.

Estates and Capital Development 2019-20

This has been an exceptionally busy year for the Estates and Capital Development Teams.

The Operational, day to day, team have been working hard alongside the Capital Development Team and One Acute Network to support design of the proposed buildings and infrastructure at both RBCH and Poole Hospitals. In addition the design for the new Macmillan Caring Locally development at Christchurch has been completed and is now ready to go out to tender and for planning.

These major changes have highlighted the need for close working relationships across the whole of the estates team, making good use of the expertise from all staff. Estates will be responsible for maintaining the new buildings and as with clinicians, have had a major say in the designs of the buildings and the services needed to make them function. There has been a lot of emphasis on planning the delivery of the new buildings and how the construction will impact day to day services.

Capital Works

Royal Bournemouth Hospital

This year, capital investments have included a new radiology intervention room, replacement of 3 X-ray machines, continuing upgrades within theatres, new fire doors in the hospital street, new boilers in residences, further backlog maintenance including CCTV improvements, new LED lighting in Outpatients department, fire detection in theatres. The team managed the conversion of the Springbourne Health Centre for Sexual Health Dorset and the Urgent Treatment Centre at Poole hospital. Central Sterile Services Department has seen improvement works in plant and equipment, this work is ongoing throughout 2020.

The Team continue to develop schemes that form part of the future new builds at Royal Bournemouth and Poole Hospitals this includes decanting schemes to facilitate these future developments. At Christchurch a masterplan has been proposed to indicate how the site may develop in the future incorporating the current hospital, the new Macmillan Unit along with future NHS development’s and assisted living accommodation.

The Trust has retained the Green Flag award celebrating our commitment to providing high quality external spaces for staff and patients to access and enjoy.

Our sustainability manager Laura Dale left the Trust to work closer to home and we welcome Stuart Lane from Poole who will lead on sustainability for both Poole and RBCH.

2019-2020 has, overall be a year focussed on planning for the future and ensuring that the planned developments can be delivered with the minimum of impact on day to day services. As we enter the final design stages and prepare for work on site to start in early 2021 we look forward to a time of massive change, and welcome the challenges ahead.

Operational Performance 2019-20

1. Overview

2019/2020 has been a truly exceptional year in many ways, with some unprecedented and extreme issues to contend with. This has led to the decline in operational performance that will take at least a year or more to recover.

Most of the year was affected by two key issues, pensions and funded capacity. The NHS pensions and the tax taper meant many senior clinicians could not provide the extra hours the NHS relied upon for services to meet operational targets. This is resolved from April 2020, but the backlog built up is very significant. This came on top of the mismatch between funded capacity and the growth in demand, which after three years of ‘fixed’ funding has led to recurrent shortfalls in most areas of elective care, even after productivity and pathway improvements. Cancer and the most urgent treatments have continued to be prioritised with RBCH performing better than the national comparisons in Cancer Standards. Extra funding in the final three months of the year helped make a one-off improvement, however Covid-19 affected March and thus the final year end position was not recovered.

More positively progress was made throughout the year on stranded patients, which is good for the individual in reducing harm and improving independence. It also helps in freeing hospital resources to treat sicker patients. These measures then improved in an unprecedented way when Covid-19 required the discharging of patients who no longer needed acute care in hospitals from early March.

All told this has been a challenging year, and with the uncertainties of 2020/2021, recovery will take time and persistence. However the knowledge performance has been recovered before, and our staff remain talented, committed and hardworking, all give confidence that the situation will improve. Thanks to all our staff who have worked through adversity and challenge for their hard work and dedication.

2. Single Oversight Framework (SOF) (national indicators)

The Emergency Department (ED) four hour standard was not met, and remained around the national level of performance. Only one twelve hour breach was recorded, achieving this standard.

Referral to Treatment (RTT) for outpatient and elective procedures saw an increase in both numbers waiting and the longest waits for routine procedures. The RTT percentage fell below the national average performance, for the first time since this standard was introduced.

Cancer waits remained better than the national standard for most of the year and much better than national average for the whole year.

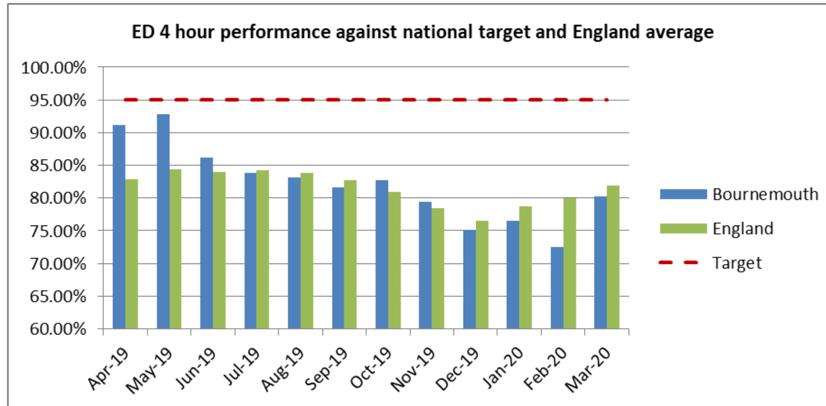
Diagnostic waits for radiology and cardiology met the national standard of 99% in six weeks, but endoscopy saw a mix of serious issues that meant waiting time performance dropped to levels not seen before. National quality accreditation was maintained in all areas except waiting times. Year-end recovery made significant inroads, but a backlog remains, which is clinically prioritised.

Patients awaiting discharge (‘stranded patients’) and overall lengths of stay fell through the year, which is a positive endorsement of partnership working and improved internal processes.

3. Emergency Access

For many years the four hour standard was seen as a simple but effective yard stick of the many facets of emergency care. However 2019/2020 saw the field testing of a new, more sophisticated set of measures, with Poole Hospital as one of the 14 test sites nationally. As a result there has been greater focus on specific measures, especially for the sickest patients, and lower priority for “walk in” patients, within the pilot sites. “Shadow Reporting” at RBCH is preparing for the changes to come.

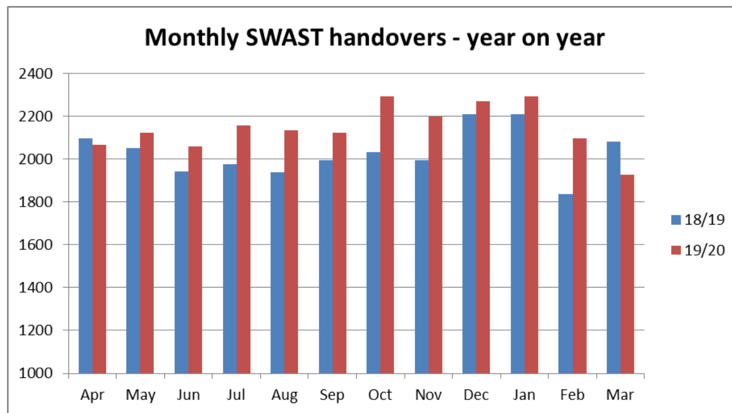
Graph 1 – national A&E 4 hour performance benchmarking – March 2020



Month	National Target	England Average	Actual RBH
Apr-19	95%	82.82%	91.15%
May-19	95%	84.33%	92.75%
Jun-19	95%	84.02%	86.21%
Jul-19	95%	84.19%	83.84%
Aug-19	95%	83.88%	83.20%
Sep-19	95%	82.74%	81.64%
Oct-19	95%	80.87%	82.74%
Nov-19	95%	78.42%	79.41%
Dec-19	95%	76.57%	75.12%
Jan-20	95%	78.66%	76.48%
Feb-20	95%	79.96%	72.51%
Mar-20	95%	81.88%	80.18%

On the ground the year on year increase in ambulance admissions, and a higher level of acuity outstripped even the increases planned and funded. This resulted in four hour performance declining to around the national average. This mirrored the national decline with no ED meeting the standard for the whole year. Of note the number of patients admitted from ED into the hospital rose, indicating higher acuity, and placing pressure upon the rest of the hospital.

Graph 2 – year on year monthly ambulance handovers – March 2020

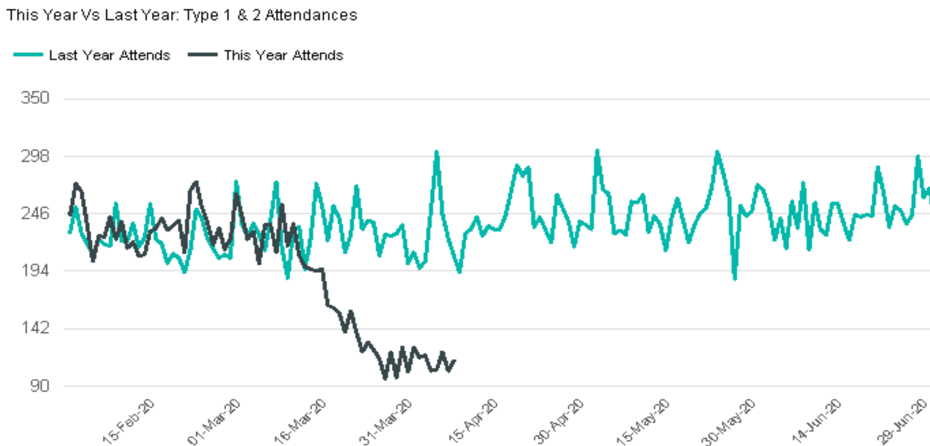


Work on processes, workforce, leadership and culture, were all progressed with gusto throughout the year. This included an expansion of the ED consultant coverage at evenings and weekends and an increase in nursing staff. Work with partners including the ambulance services, social workers in ED, psychiatric liaison service, and the integrated urgent care service have all been positive.

March 2020 saw an unprecedented fall in ED attendances, due to Covid-19, which skews some of the annual figures. During this time there needed to be “two EDs” to separate patients, more time with each patient and staff wearing Personal Protective Equipment (PPE). This all led to a heavier workload, despite the lower patient numbers.

Month	Handovers	Month	Handovers
Apr-18	2095	Apr-19	2065
May-18	2051	May-19	2124
Jun-18	1944	Jun-19	2060
Jul-18	1976	Jul-19	2158
Aug-18	1937	Aug-19	2136
Sep-18	1997	Sep-19	2125
Oct-18	2032	Oct-19	2291
Nov-18	1996	Nov-19	2199
Dec-18	2209	Dec-19	2269
Jan-19	2210	Jan-20	2292
Feb-19	1837	Feb-20	2095
Mar-19	2081	Mar-20	1927

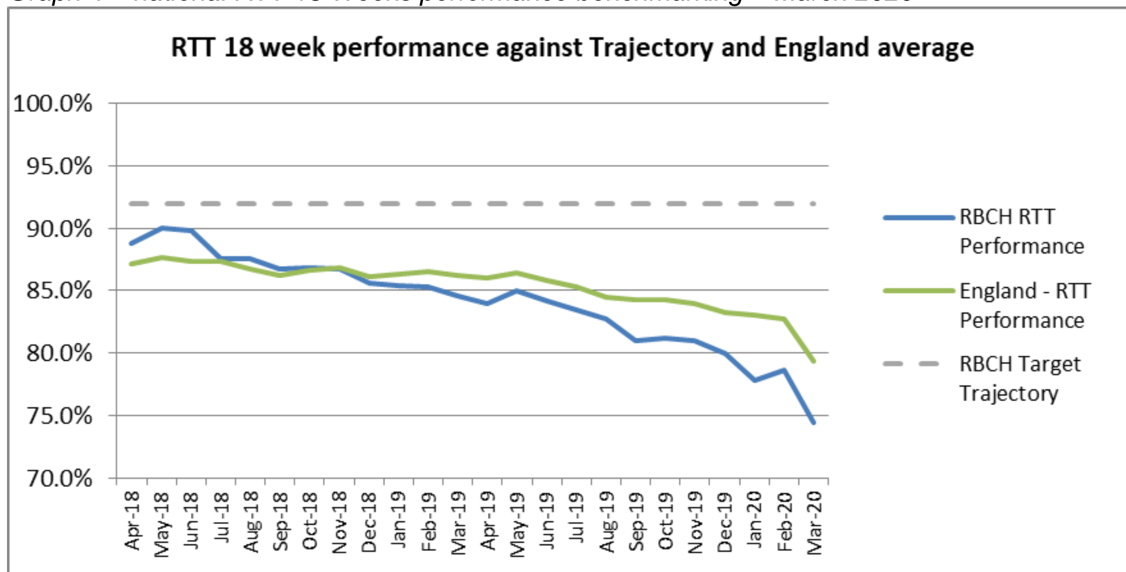
Graph 3 ED attendances this year vs last Year: Type 1 and 2 Attendances



The Get it Right First Time (GIRFT) review of ED in 2019 was overall positive, with RBCH seen as a top quartile performer in the range of quality measures and productivity that GIRFT reviews.

4. RTT elective care

Graph 4 – national RTT 18 Weeks performance benchmarking – March 2020



Month	National Target	England Average	Actual RBH
Apr-19	92%	86.06%	83.98%
May-19	92%	86.39%	84.96%
Jun-19	92%	85.83%	84.16%
Jul-19	92%	85.30%	83.43%
Aug-19	92%	84.45%	82.75%
Sep-19	92%	84.33%	80.98%

Oct-19	92%	84.23%	81.21%
Nov-19	92%	83.94%	80.97%
Dec-19	92%	83.24%	79.92%
Jan-20	92%	83.04%	77.82%
Feb-20	92%	82.75%	78.60%
Mar-20	92%	79.31%	74.45%

RTT saw an increase in patients waiting and the proportion of these over 18 weeks. Whilst RBCH retained a lower proportion of long waiters (over 40 weeks) than many Trusts, the growth of this cohort in year has been a major concern. Whilst clinical prioritisation has meant these long waiting patients have more "routine" conditions, these are still serious enough to require treatment, and can often be painful or limiting.

The major causes have already been set out:

- Firstly a reduction in consultant and senior doctor time for the year, due to pension penalties, making it often more expensive to work extra shifts than to stay at home. Suggested in year remedies had little impact and so routine operating lists had to be reduced. During summer 2019 over 10 hours of operating time a day had to be stood down, during the very months routine work is normally "caught up" from the winter.
- The second, multi-year issue is the growing mismatch between capacity and demand. Funding limitations and the need to stay within "control totals" has led to trade-offs between the amount of new expenditure available to increase capacity, to match rising demand. Whilst the Trust, and Dorset as a whole, has consistently met the financial control total for three years, the year on year gap has grown for services to meet patient demand.

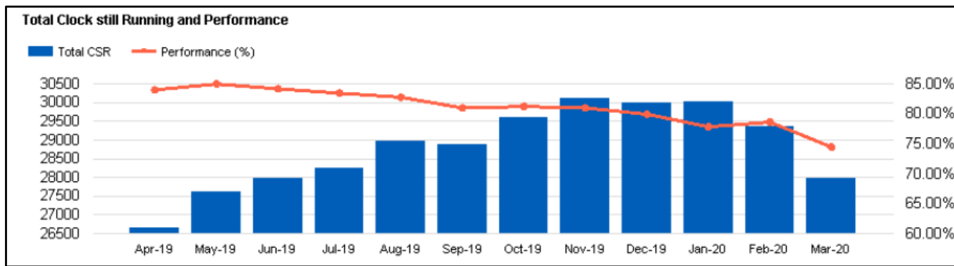
Successful work has increased productivity in theatres and switching work away from traditional outpatient attendances. Work in collaboration with GPs has seen routine referrals reduced, however what remains are the more complex, and acute conditions requiring more hospital resources per patient. Cancer "fast track" referrals have continued to rise with double digit growth for over three years. These referrals require more 'upfront' testing and clinical input, and hence resources available for routine, non-urgent care, is further squeezed. It also means simple "one only" attendances have reduced, which further impacts RTT percentage performance negatively.

These combined factors have seen waits increase in both total number of patients and those waiting over 18 and 40 weeks, as well as some over 52 weeks (see Table 1 and Graph 6).

Some one-off extra funding confirmed in January 2020 allowed some extra activity by outsourcing some work during the winter period. This made a significant impact (see Graph 5) in slowing, and then reversing waiting numbers, but unfortunately was overtaken by Covid-19 and the need to stop routine work in March 2020.

Overall the decline in RTT is a significant concern, which will be a focus in the recovery following Covid-19. Whilst resolution of the pension issue is one impediment removed, the underlying balance of capacity and demand, and the accumulated backlog, will be a significant and costly set of issues for the years ahead.

Graph 5 RTT Clocks still running increase vs Performance national target 92%

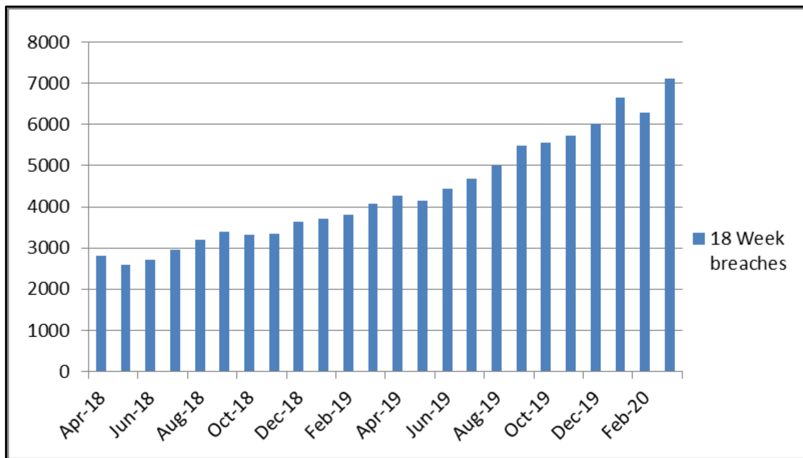


Month	CSR	Performance
Apr-19	26653	83.98%
May-19	27614	84.96%
Jun-19	27978	84.16%
Jul-19	28248	83.43%
Aug-19	28971	82.75%
Sep-19	28876	80.98%
Oct-19	29592	81.21%
Nov-19	30114	80.97%
Dec-19	29975	79.92%
Jan-20	30028	77.82%
Feb-20	29348	78.60%
Mar-20	27979	74.45%

Table 1 - 40+ week incomplete pathways by specialty

Specialty	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
General Surgery	40	46	57	81	99	118	109	102	106	91	108	131
Urology	58	55	48	58	74	83	69	71	66	60	73	81
Trauma & Orthopaedics	4	4	2	2	5	8	8	3	7	16	15	39
Ear, Nose & Throat (ENT)	2	0	1	1	3	9	7	5	6	10	12	23
Ophthalmology	18	38	36	28	60	62	38	29	29	22	27	40
Oral Surgery	5	6	1	2	11	5	8	18	30	22	31	34
Cardiothoracic Surgery	0	0	0	0	0	0	0	0	0	0	0	0
General Medicine	5	5	3	2	6	5	9	6	15	9	13	31
Cardiology	4	1	4	2	10	8	11	21	26	24	29	17
Dermatology	1	0	0	1	0	0	0	1	1	1	3	1
Thoracic Medicine	1	0	1	1	0	1	0	0	1	4	0	1
Neurology	0	0	1	1	0	1	2	2	2	4	3	1
Rheumatology	0	0	0	1	0	0	0	0	0	1	0	1
Geriatric Medicine	0	0	0	0	1	0	0	0	0	0	0	0
Gynaecology	5	8	15	16	18	19	23	19	25	32	29	40
Other	2	8	9	7	7	13	18	15	21	20	33	41
Total	145	171	178	203	294	332	302	292	335	316	376	481

Graph 6 - Numbers of patient's past 18 weeks

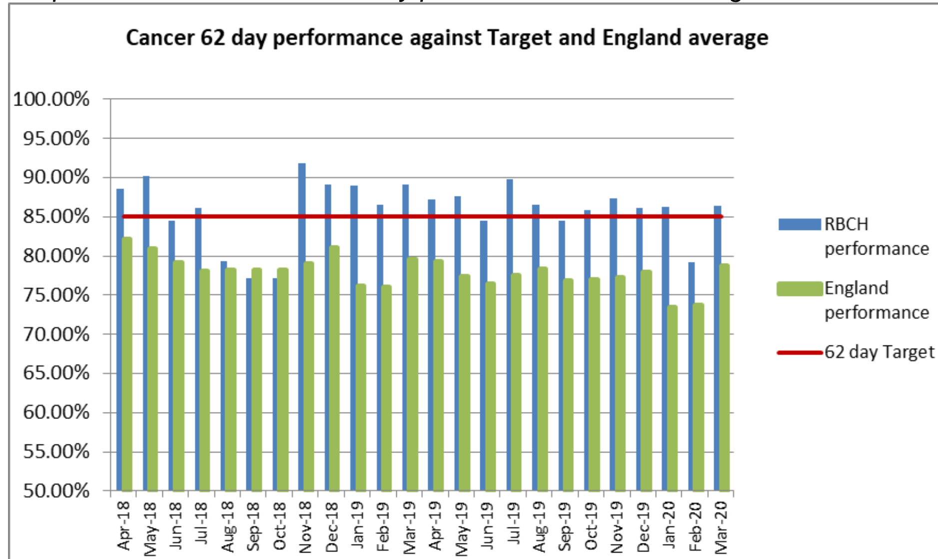


Month	RTT Over 18 Weeks
Apr-18	2815
May-18	2597
Jun-18	2702
Jul-18	2961
Aug-18	3199
Sep-18	3385
Oct-18	3315
Nov-18	3333
Dec-18	3634
Jan-19	3711
Feb-19	3804
Mar-19	4066
Apr-19	4270
May-19	4153
Jun-19	4431
Jul-19	4681
Aug-19	4998
Sep-19	5493
Oct-19	5561
Nov-19	5731

5. Cancer Care

The operational standards for cancer are about access times however it should be noted RBCH also performs very well in outcomes and patient satisfaction. During the year the Trust was selected to be amongst a handful of Trusts piloting the proposed new standard of 28 days to diagnosis. This builds on years of pathway redesign, and excellent multi-disciplinary team (MDT) working, as well as matching capacity and demand.

Graph 7 – national Cancer 62 Day performance benchmarking – March 2020



Month	National Target	England Average	Actual RBH
Apr-18	85.00%	82.23%	88.60%
May-18	85.00%	81.02%	90.20%
Jun-18	85.00%	79.15%	84.50%
Jul-18	85.00%	78.11%	86.13%
Aug-18	85.00%	78.18%	79.39%
Sep-18	85.00%	78.18%	77.20%
Oct-18	85.00%	78.27%	77.10%
Nov-18	85.00%	79.08%	91.80%
Dec-18	85.00%	81.04%	89.15%
Jan-19	85.00%	76.24%	88.98%
Feb-19	85.00%	76.10%	86.60%
Mar-19	85.00%	79.60%	89.10%
Apr-19	85.00%	79.31%	87.26%
May-19	85.00%	77.38%	87.63%
Jun-19	85.00%	76.55%	84.53%
Jul-19	85.00%	77.53%	89.80%

Aug-19	85.00%	78.43%	86.50%
Sep-19	85.00%	76.88%	84.50%
Oct-19	85.00%	77.04%	85.84%
Nov-19	85.00%	77.26%	87.34%
Dec-19	85.00%	77.93%	86.16%
Jan-20	85.00%	73.52%	86.30%
Feb-20	85.00%	73.71%	79.20%
Mar-20	85.00%	78.81%	86.40%

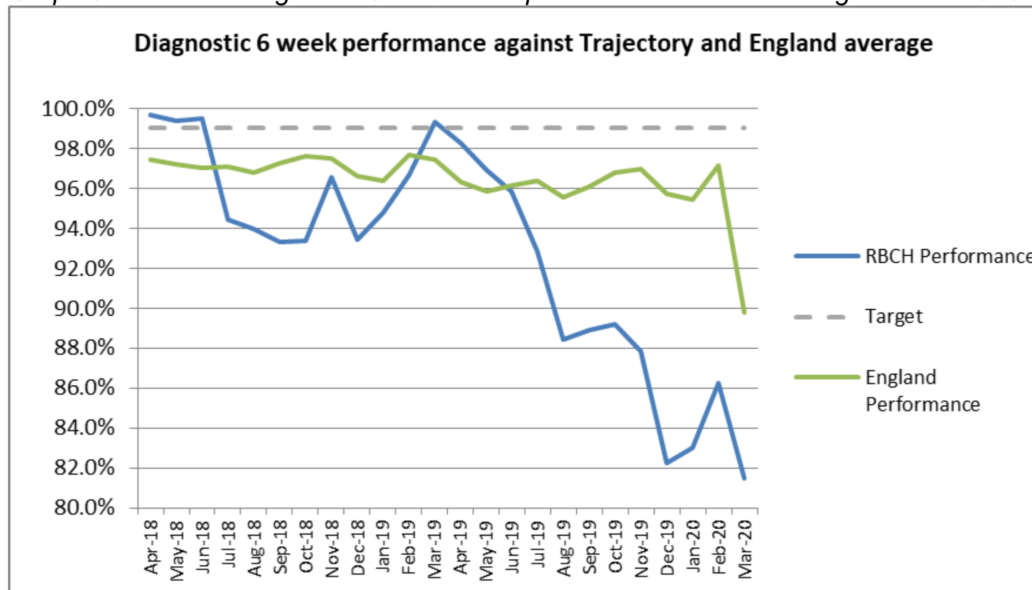
The 62 day fast track Cancer standard was met each quarter, one of the few Trusts to achieve this. This was despite in year challenges of workforce and workload.

Taken together with the continued high performance in waiting times, cancer care has remained an area that has rightly been proud of its achievements for patients.

6. Diagnostic waits

Radiology and cardiac diagnostics have dealt well with rising demand and both workforce and equipment challenges. Despite these there has been continued strong performance against the 99% of patients having their test in less than six weeks, with most in considerably less time.

Graph 8 – national Diagnostic 6 Week Wait performance benchmarking – March 2020



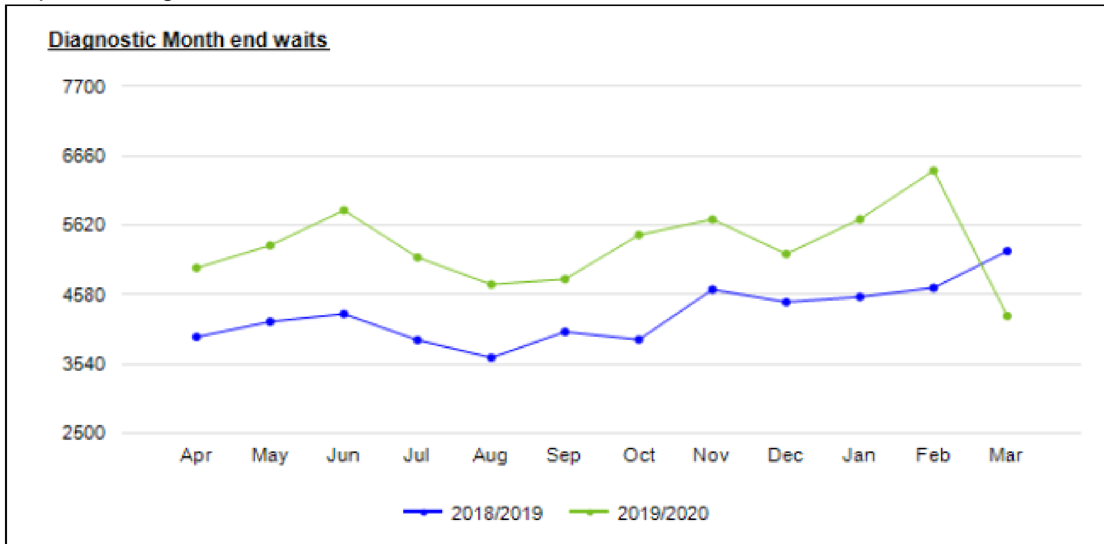
Month	National Target	England Average	Actual RBH
Apr-19	99%	96.32%	98.27%
May-19	99%	95.84%	96.93%
Jun-19	99%	96.16%	95.82%
Jul-19	99%	96.41%	92.82%
Aug-19	99%	95.58%	88.42%
Sep-19	99%	96.10%	88.92%
Oct-19	99%	96.79%	89.22%
Nov-19	99%	96.96%	87.87%
Dec-19	99%	95.71%	82.25%
Jan-20	99%	95.45%	83.01%
Feb-20	99%	97.16%	86.27%
Mar-20	99%	89.81%	81.48%

The very high volume endoscopy service has had a series of challenges that meant at the start of the year despite a positive capacity and demand planned performance soon fell well below the 99% standard. Key issues included:

- Long term unexpected sickness amongst a significant number of high volume endoscopists, reducing numbers of procedures.
- The pension issue (explained within the RTT section) having a large impact as over 10% of endoscopy is undertaken as “extra” lists, often backfilling leave of other colleagues.
- Growth in procedures required, especially as fast track referrals have grown sharply.

A large part of the one off funding in late 2019/2020 has prioritised “insourced” weekend lists to catch up. Also a positive is that two of the issues (sickness and pensions) are thankfully resolving. There is also widespread understanding that endoscopy rates are likely to increase annually by five to ten percent until we reach European levels of intervention and therefore commissioners and workforce planners will need to fund extra capacity.

Graph 9 – Diagnostic month end waits



Month	Month end Waits	Month	Month end Waits
Apr-18	3945	Apr-19	4979
May-18	4173	May-19	5317
Jun-18	4290	Jun-19	5843
Jul-18	3898	Jul-19	5137
Aug-18	3633	Aug-19	4731
Sep-18	4022	Sep-19	4812
Oct-18	3904	Oct-19	5473
Nov-18	4655	Nov-19	5707
Dec-18	4467	Dec-19	5189
Jan-19	4545	Jan-20	5710
Feb-19	4680	Feb-20	6437
Mar-19	5232	Mar-20	5446

7. Stranded patients

This area has been of considerably increased focus in 2019/2020 given the strong evidence base of harm to patients if they become 'stranded' in hospital, i.e. not requiring hospital care but unable to move home. Whilst fairly crude measures such as patient stays at 14 and 21+ days, and numbers "medically ready for discharge", these have been found to be good proxies for a functioning system. Progress was made in each quarter of the year however the Covid-19 effect in March, had a significant impact on reducing admissions and patient numbers. RBCH and partners have made good progress and many patients have benefitted.

Table 2 Monthly and YTD Stranded patients

	Month		
	Mar-19	Mar-20	% Variance
Number of patients who have been in the hospital for >7 days	237	110	-53.59%
Number of patients who have been in the hospital for >21 days	84	42	-50.00%
Number of patients who have been in the hospital for >21 days who are medically fit for discharge	34	11	-67.65%

Table 3 Stranded patients by quarter

Stranded Patients	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4
Number of patients who have been in hospital for > 7days	720	666	650	592
Number of patients who have been in hospital for > 21days	280	233	215	188
Number of patients who have been in hospital for > 21days who are medically fit for discharge	126	110	78	77
Total number of days delayed within the month	1529	1669	1165	971

At the start of the Covid-19 pandemic, our hospital had to prepare for any sudden rise in critically ill patients. We had to ensure that any patient who was medically ready for discharge left the hospital to be supported either at home or in the community. We can learn a lot from this experience as we worked closely with all our partners across the Our Dorset Integrated Care System.

Debbie Fleming, Interim Joint Chief Executive, 24 June 2020

Sustainability Report 2019-20

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. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met and the health and wellbeing of our community and natural environment is fostered in both the short and long term.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our Carbon footprint.

It is our duty to, as a part of the NHS, public health and the social care system contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. The Trust is pleased to report that we have met this target and are now studying the challenge set by government to reach net zero emissions.

The Trust is committed to continually improve on minimising the impact of its activities on the environment, and in doing so reinforcing its commitments to the United Nations Sustainable Development Framework.

In order to meet these targets we are working in a number of areas to invest in low-carbon technologies and practices outlined within the following below.

The key areas for action are:

- energy, water and carbon management
- sustainable procurement and food
- low carbon travel, transport and access
- waste reduction and recycling
- green spaces
- staff engagement and communication
- sustainable models of care
- buildings and site design
- organisational and workforce development
- partnership and planning
- governance, IT and finance.

Monitoring, reviewing and reporting of energy and carbon management are carried out quarterly via the Carbon Management Group.

We have been progressing with energy and carbon management in a number of areas over the last couple of years.

CELEBRATING OUR SUCCESSES IN 2019/20

Energy, water and carbon management

The Trust has continued to participate in the demand side response project for a fifth year. This project involves reducing the hospitals load from the national grid at peak times by running off backup generators and exporting excess energy back into the grid. The hospital has also initiated a project to install exhaust scrubbers in the Royal Bournemouth Hospital's main generators to lower the emissions from the plant.

The Trust now generates roughly 22% of energy requirements onsite, through 3 solar PV installations and low pressure hot water, which is produced as a by-produce of onsite incineration and used to subsidise the Royal Bournemouth Hospitals' heating systems.

In 2019/20 the Trust continued a water saving initiative in partnership with ADSM. Through this initiative, ADSM donated 1% of revenues generated to Water Aid. Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust have helped transform lives in rural Mozambique, by bringing fresh water to 49,072 people.

Sustainable procurement and food

In 2019/20 the hospital has continued to promote the sourcing of local and seasonal produce, reducing our environmental footprint and supporting the health and wellbeing of our staff and patients. In such, the catering department successfully maintained the Silver Award in Food for Life Accreditation. This catering mark provides an independent endorsement that the food served at the hospital is prepared on site using fresh ingredients which are free from undesirable additives and trans-fats, are better for animal welfare, and comply with national nutrition standards.

The Trust acknowledges the importance of sustainable procurement and its role as an agent for change in the broader sustainable development agenda. We recognise our responsibility to carry out procurement activities in an environmentally and socially responsible manner, which this is reflected in the Trust's Sustainable Procurement Policy and associated action plan, which have been approved by the Procurement Steering Board.

Low carbon travel, transport and access

The Trust understands that we can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel and have produced an Active Travel Plan.

A staff and patient travel survey was carried out in 2019 to help inform our Travel Plan and to help identify initiatives to encourage or improve routes for public transport and identify activities to encourage active travel.

We also recognise that an Active Travel Plan is a foundational part of our Travel Policy and we will be putting that in place as soon as possible. This policy forms a part of the planning applications submitted for developments at both Poole and Bournemouth Hospitals.

The Trust has worked hard over the last 10 years on introducing and supporting measures to ease traffic congestion around the hospital, through a combination of promoting sustainable travel and pursuing improvements to the local transport infrastructure.

The Trust continues to provide incentives for the use of public transport such as discounted bus pass prices, extensive cycle parking facilities, locker and shower facilities, an organisational cycle to work scheme, free parking for motorcycles within the hospital grounds, and access to Trust pool vehicles.

The Trust has invested in a number of electric vehicles and electric vehicle charging stations, including electric vehicle charging available to the general public within the Royal Bournemouth Hospital public car park.

The Trust has a number of teleconferencing facilities across the Hospitals and has recently rolled out the deployment of Microsoft Teams onto all staff computers, further encouraging the use of teleconferencing and reducing unnecessary travel.

Waste reduction and recycling

The Trust became 'zero waste to landfill' back in 2012/13, with all general non-recyclable waste being sent to an Energy Recovery Facility, which in turns helps to supply energy to local homes. Recycling facilities continued to be rolled out across the Trust in clinical and office areas of the hospital. The Trust has also continued send all food waste from the Catering Department to a local Anaerobic Digestion (AD) plant where it is used to produce energy for the national grid, and by-product liquid fertiliser to local farmers.

A food waste workshop facilitated by Food for Life, Soil Association, was carried out in 2019, looking at reducing the amount of food waste generated within the ward environments. Key members of clinical staff were invited to the workshop from each of the clinical areas and an action plan produced and implemented.

The Trust also signed up to the NHS Single Use Plastics Reduction Campaign Pledge in 2019. This commits the Trust to reducing the amount of plastics within catering environments substantially over the next 3 years.

Battery recycling facilities are also continuing to be rolled out across the Trust.

Buildings and site design

Dorset CCG decision to progress the CSR transformation of clinical services will increase the size of our hospital to accommodate significantly more activity. Planning is underway to determine what our hospital site will look like once these developments are complete. The Trust is endeavouring to ensure that any new builds or extensions to our site will work to improve the efficacy of our built environment. New building will aim comply with the Excellent BREEAM standard. An internationally recognised measure of a building's design and engineering to ensure a minimum environmental impact whilst ensuring the internal environment meets strict standards. The impact on local bio diversity, ground water, air quality and noise are also considered.

Green spaces

The Trust recognises the importance of regular access to natural environments for its patients, staff and visitors. The Trust wants to raise the awareness of biodiversity and sustainable practices to help promote the link between green spaces and their positive benefits for mental health & wellbeing.

The Trust has again maintained their Green Flag Award, recognition of the efforts of the Estates Team at Royal Bournemouth Hospital, who have produced and implemented a detailed Biodiversity Management Plan. This plan will help to ensure that the Trust continues to provide a quality green space that provides staff and patients a sanctuary for rest and recuperation.

The Estates Department have adopted sympathetic and sustainable approaches to their management of the hospital grounds, including log piles to encourage biodiversity and wildlife, introduction of wildflower meadows, installation of bird boxes and duck houses, limited use of pesticides, green pest control in the form of a Harris Hawk, recycling of waste plant material, and an interpretive board was erected by the lakeside to communicate the wildlife present on site.

Since receiving the Green Flag Award, several new gardens have been created in the external green spaces and in the internal courtyards. Staff have also been encouraged to make use of green and natural areas on our estate even where land is constrained. Many departments have adopted local, previously unused, courtyards within Royal Bournemouth Hospital. The Pharmacy Department have created a very popular garden within one of the courtyards and staff feedback has been very positive about it providing a space in which they can retreat during their breaks.

Staff engagement and communications

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

The Trust was the second NHS organisation to take part in the Green Impact Scheme, an environmental accreditation and awareness project run by the National Union of Students. The Trust has now been running this scheme for over seven years. During 2019/20, 13 teams took part across the Trust, with 462 greening actions completed. It is expected that 5 teams will be awarded 'working towards', 1 bronze award, 3 silver awards, 3 gold awards and 1 'Excellence Award- the highest possible award in the scheme. Alongside this the Trust has also continued the promotions of the SustainRBCH Campaign - an energy awareness and switch off campaign which works to promote the links between energy savings and more comfortable patient and staff environments.

Regular articles about sustainability and energy awareness are included within the staff magazines, as well as regular awareness raising events, such as the National Climate Week campaign and annual NHS Sustainability Day.

Sustainable Models of Care

Sustainable Models of care are where health outcomes are explicitly embedded with social and environmental sustainability and are a core and measureable dimension that underpins quality. 2019/20 saw the Trust Sustainability Team try and embrace this by running the Green Ward Competition at RBCH. The Trust partnered with The Centre of Sustainable Healthcare (CSH) to deliver this project and saw clinical teams work with CSH staff to develop and take forward a sustainability project in their ward over a couple of months. We had 5 teams take part; the Pharmacy Department, the Eye Unit, the Immunology Department, Ultrasound and X-ray, and Theatres Recovery. The project was a great success delivering projects such as encouraging inhaler recycling and feasibility studies for medicine reuse. The awards ceremony will be held in September 2020 and opportunities have been identified to expand good practice to other areas

Organisational and workforce development

A range of initiatives associated with health improvement and promoting the health of staff, patients and the public are led and overseen by the Valuing Staff and Wellbeing Group.

Partnership and planning

The Trust continues to work in partnership with key stakeholders under local strategic partnerships to ensure the collaboration aids the integration of the sustainability agenda. These areas include improving public transport services, activities to improve cycling infrastructure and participation in Business Travel Network events.

Governance

Performance against targets is reported quarterly to the Carbon Group. A Sustainable Development Policy has also been signed off on behalf of the Trust by the Carbon Group. The Trust also routinely reports on energy consumption through the Department of Health 'Estates Returns Information Collection mechanism' (ERIC).

IT and finance

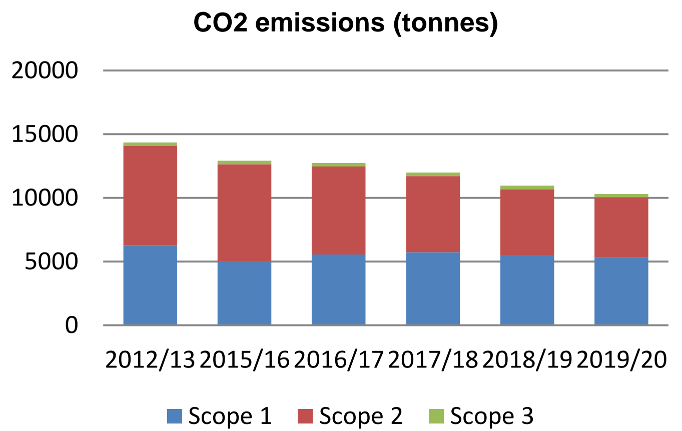
The Trust has introduced sustainability criteria as part of all business cases. The IT department has rolled out a number of energy and waste reduction projects. These include PC power management software, aimed at reducing energy consumption through computers being left on unnecessarily, introduction of iPads within the Pharmacy department to reduce paper-rounds, and the roll out of central Multi-Function Device (MFD) printers alongside the removal of personal desktop printers. The IT department have also recently rolled out Microsoft Teams to all staff, further encouraging the use of teleconferencing and reducing unnecessary travel. These facilities have been put to good use to help achieve social distancing during the Covid-19 response which has accelerated and helped to socialise these new working practises.

FUTURE PRIORITIES AND TARGETS FOR 2020/21

- Produce a Climate Change Adaptation Strategy
- Develop a Green Plan (formerly known as Sustainable Development Management Plan) for the merged Trust, for consideration by the board.
- Continue to update progress of the Trust against the Sustainable Development Assessment Tool
- Project to reduce the environmental impact of anaesthetic gases.
- Develop plans for cutting business mileage and fleet air pollutant emissions

PERFORMANCE DATA:

Greenhouse gas emissions and energy use:		**2012-13**	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Non-financial indicators (tonnes CO_{2e})	Total gross emissions:	14,351	12,754	12,023	10,956	10,275
	Gross emissions (Gas/oil/fleet vehicles/refrigerant losses)	6,283	5,566	5,784	5,492	5,289
	Gross emissions (Electricity)	7,819	6,897	5,959	5,190	4,722
	Gross emissions (waste/ water)	249	291	281	274	264
Related energy consumption (MWh)	Electricity: non-renewable	9,986	13,346	13,396	14,712	14,943
	Electricity: renewable	3,713	108	107	98	92
	Gas	20,250	16,310	16,314	16,313	15,230
	Oil	278	1,435	1,522	738	459
	LPHW	6,820	7,143	7,939	7,898	8,551
Financial indicators (£1,000's)	Expenditure on energy	2,325	2,383	2,390	3,037	3,165
Energy consumption (MWh) per GIA floor area:		0.38	0.33	0.34	0.34	0.34
Carbon emissions (Kg CO_{2e}) per patient:		19.0	16.1	15.3	14.2	14.9



Performance commentary

The gross carbon emissions for RBCH have reduced by 5.9% from the previous year and have decreased by 28.1% since the baseline year (2012/13), meeting early the target set for 2020/21.

Carbon emissions per patient have reduced by 21.6% since the baseline year.

Energy costs increased by 4% in 2019/20, this is mainly due to increases in the cost of electricity, the consumption having increase only 1.5%.

The consumption of gas within the Trust remained unchanged from the previous year.

Solar PV generated 6% less energy this year for the Trust due to downtime for maintenance and upgrades.

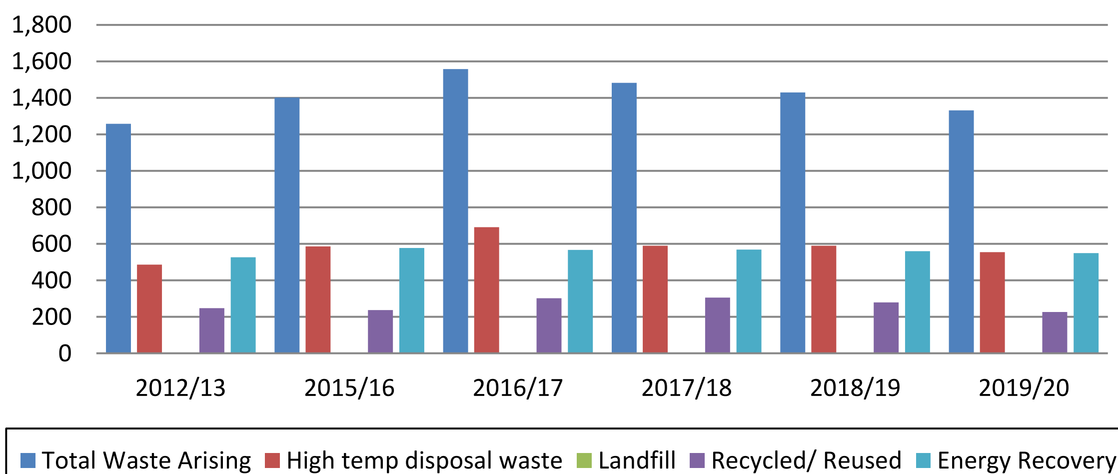
The Trust has seen a 38% reduction of oil use compared to the previous year due to more efficient management of the boilers.

Energy consumption per gross internal floor area is unchanged since last year and has reduced by 10.5% since the baseline year for energy consumption 2012/13.

Waste:		2012-13	2016-17	2017-18	2018-19	2019-20
Non-financial indicators (tonnes)	Total waste	1,258	1,557	1,482	1,432	1,360
	High temp disposal waste	486	692	589	590	554
	Landfill	0	0	0	0	0
	Recycled/ reused	247	302	305	282	256
	Energy recovery	526	567	568	560	550
Financial indicators (£1,000's)	Total waste cost	320	342	320	341	328
	High temp disposal waste	237	253	230	234	227
	Landfill	0	0	0	0	0
	Recycled/ reused	13	18	16	27	36
	Energy recovery	65	71	74	79	65

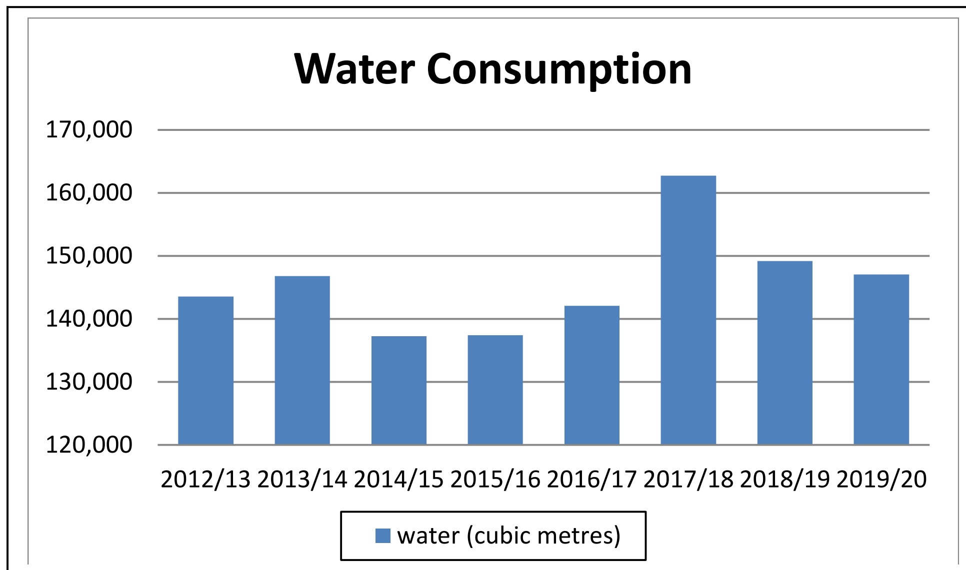
Performance commentary:

In 2019/20, 550 tonnes of waste went to an energy recovery facility and 256 tonnes were recycled, which included mixed recycling (45 tonnes) and baled cardboard (117 tonnes). Trust has chosen to send all waste to energy recovery as opposed to landfill as of financial year 2012/13.



Water:		2012-13	2016-17	2017-18	2018-19	2019-20
Non-financial indicators (000's m^3)	Water consumption	144	142	163	149	147
	Sewerage	108	101	108	106	105
Financial indicators (£1,000's)	Water supply costs	139	127	135	167	164
	Sewerage costs	170	166	140	184	178
Water usage per GIA (floor area)		1.35	1.22	1.40	1.28	1.27

Commentary:



RBCH water consumption has decreased by 1.3% in 2019/20 compared to the previous year, but has increased by 2.1% compared to the baseline year (2012/13).

This year, water consumption per square meter of gross internal floor area has also shown an overall decrease of 5.9% compared to the baseline year (2012/13).

Accountability Report

Directors' Report

Board of Directors

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

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

The members of the board of directors during 2019-20 are listed below.

Non-Executive Directors

David Moss, Chairperson

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

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

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

Pankaj Davé, Non-Executive Director

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

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

Christine Hallett, Non-Executive Director

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

Christine chairs the Healthcare Assurance Committee, is a member of the Audit Committee and is the Senior Independent Director (SID).

Alex Jablonowski, Non-Executive Director

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

John Lelliott OBE, Non-Executive Director

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

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

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

Iain Rawlinson, Non-Executive Director

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

Iain is a member of the Audit, Charitable Funds and Finance and Performance Committees. Iain was also a member of the Workforce Strategy and Development Committee until November 2019.

Cliff Shearman, Non-Executive Director

Cliff Shearman was appointed as a non-executive director in April 2017. Cliff was a Professor of Vascular Surgery/ Consultant Vascular Surgeon at University Hospital Southampton NHS Foundation Trust until 2016, where he was also Associate Medical Director. He was Head of the Wessex Postgraduate School of Surgery from 20072012. Cliff is now Emeritus Professor of Vascular Surgery at the University of Southampton.

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

Executive Directors

Debbie Fleming, Chief Executive

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

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

Karen Allman, Director of Human Resources

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

Peter Gill, Director of Informatics

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

Alyson O'Donnell, Medical Director

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

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

Pete Papworth, Director of Finance

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

Richard Renaut, Chief Operating Officer

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

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

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

Paula was appointed Deputy Chief Executive for RBCH in 2014.

Each director has declared their interests at public meetings of the board of directors. The register of interests is available on the Trust's website.

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

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

Role of the board of directors

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

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

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

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

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

Board meetings

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

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

Attendance at Meetings of the Board of Directors		
Name	**Title**	**Attendance**
Karen Allman	Director of Human Resources	4 (4)
Pankaj Davé	Non-Executive Director	4 (4)
Debbie Fleming	Joint Interim Chief Executive	3 (4)
Peter Gill	Director of Informatics	4 (4)
Christine Hallett	Non-Executive Director	3 (4)
Alex Jablonowski	Non-Executive Director	4 (4)
John Lelliott	Non-Executive Director	4 (4)
David Moss	Joint Interim Chairperson	4 (4)
Alyson O'Donnell	Medical Director	3 (4)
Pete Papworth	Joint Interim Director of Finance	4 (4)
Iain Rawlinson	Non-Executive Director	3 (4)
Richard Renaut	Chief Operating Officer	3 (4)
Cliff Sherman	Non-Executive Director	3 (4)
Paula Shobbrook	Director of Nursing and Midwifery	3 (4)

Non-Executive Directors

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

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

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

Where appropriate, and as required, the Chairperson and the non-executive directors meet without the executive directors present. One meeting took place during 2019-20.

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

Non-Executive Director	Appointed	Term of office
Pankaj Davé	1 September 2018	1 year
Christine Hallett	29 June 2015 Reappointed on 29 June 2018	3 years 3 years
Alex Jablonowski	20 June 2016 Reappointed 20 June 2019 1 October 2017 as Vice-Chairperson Reappointed on 1 October 2019 as Vice-Chairperson	3 years 3 years 2 years 2 years
John Lelliott	1 June 2016 Reappointed 1 June 2019	3 years 3 years
David Moss	13 March 2017 (appointed as joint chair of the Trust and Poole Hospital NHS Foundation Trust on 1 January 2019)	3 years 3 years
Iain Rawlinson	1 October 2017	3 years
Cliff Shearman	1 April 2017 Reappointed on 1 April 2020	3 years 3 years

Board evaluation

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

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

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

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

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

Audit Committee

The Trust's Audit Committee meets at least quarterly and representatives from the external auditor, internal auditors and the counter fraud service attend these meetings. The Director of Finance, Director of Nursing and Midwifery, Medical Director, Director of Informatics, Freedom to Speak Up Guardian and representatives from the risk management and clinical audit teams also regularly attend meetings at the request of the Chairperson. The Audit Committee met five times during the year. The committee members are all independent Non-Executive Directors and during 2019/20 were:

Name	Meetings attended
Alex Jablonowski (Chairperson)	5 (5)
Christine Hallett	4 (5)
John Lelliott	4 (5)
Iain Rawlinson	4 (5)
Pankje Dave	1 (1)

The Audit Committee's duties cover the following areas:

- reviewing the establishment and maintenance of an effective system of internal control, risk management and corporate governance, with particular reference to the Trust's board assurance framework;
- appointing the internal auditors including the terms of appointment, agreeing the internal audit programme and reviewing the findings and recommendations from internal audit reports to provide assurance to the Board of Directors; considering the appointment of
  external auditors, including the terms of appointment, before making a recommendation to the Council of Governors, reviewing the nature and scope of the audit and the reports of the external auditors;
- considering the provision of any non-audit services to the Trust by the external auditors;
- appointing the counter fraud service including the terms of appointment, agreeing the counter fraud programme and reviewing the findings from investigations;
- monitoring management responses to internal audit, external audit and counter fraud reports and the implementation of recommendations;
- ensuring co-ordination between internal audit, external audit and the counter fraud service;
- ensuring that internal audit, external audit and counter fraud operate effectively, including appropriate resourcing and access to staff;
- reviewing the annual plan and annual report for clinical audit;

- reviewing the annual report, annual governance statement and annual financial statements before making a recommendation to the Board of Directors; and
- reviewing arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

Internal audit

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

External audit

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

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

Non-audit services

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

Counter fraud

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

Freedom to speak up (Whistleblowing)

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

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

Significant areas

During the year under report the committee continued to build its focus on information security risks including asset management, network stability, disaster recovery and cybersecurity, reviewing reports from internal audit and supporting the commissioning of other external reviews for additional assurance. The committee undertook a deep dive into the risks to the IT infrastructure including an overview of links with the digital transformation strategy. The committee approved a change to the 2019/20 internal audit plan to include an audit on the data security and protection (DSP) toolkit to meet a new mandatory element of the DSP toolkit requirements.

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

The committee also maintained a focus on a number of operational areas, which had been highlighted through internal audit reports including:

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

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

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

Council of Governors

There are 28 members of the Council of Governors. The Council of Governors' principal duties are:

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

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

In 2019-20, the Council of Governors was made up as follows:

Public governors - Bournemouth and Poole constituency	Year elected	Term
Judith Adda (from September 2019)	2019	3 years
Howard Fincher (from September 2019)	2019	3 years
Marjorie Houghton (re-elected September 2019)	2017	3 years
Mark Howell (from September 2019)	2019	3 years
Keith Mitchell	2017	3 years
Roger Parsons (until September 2019)	2017	2 years
Sue Parsons (re-elected September 2019)	2016	1 year
Alan Radley (until July 2019)	2016	3 years
Maureen Todd	2017	3 years
David Triplow (Lead Governor from 12 April 2017)	2017	3 years
Michele Whitehurst (re-elected September 2019)	2017	3 years

Public governors - Christchurch and Dorset County constituency	Year elected	Term
Richard Allen	2017	3 years
Colin Beck (from September 2019)	2019	3 years
Derek Chaffey	2017	3 years
Eric Fisher	2017	3 years
Kevin Steele (from September 2019)	2019	3 years
Brian Young (re-elected September 2019)	2017	3 years

Public governors New Forest and Rest of England constituency	Year elected	Term
Tracy Broom (until September 2019)	2017	2 years
Nick Harrison	2017	3 years
John Lewis (from September 2019)	2019	3 years
Sandy Wilson	2017	3 years

Staff governors	Staff class	Year elected	Term
Catherine Bishop	Administrative, Clerical and Management	2017	3 years
Lucy Darke (from September 2019)	Nursing, Midwifery and Healthcare Assistants	2019	3 years
Louise Johnson (until October 2019)	Allied Health Professions, Scientific and Technical	2017	3 years
Marcus Pettit	Estates and Ancillary Services	2017	3 years
Petrina Taylor (until September 2019)	Nursing, Midwifery and Healthcare Assistants	2014	3 years
Vacancy	Medical and Dental		
Vacancy	Allied Health Professionals, Scientific and Technical		

Appointed governors	Appointing organisation	Year appointed	Term
Michael Bowen (from September 2019)	The Royal Bournemouth and Christchurch Hospitals Volunteers Group	September 2019	3 years
Lesley Dedman (until May 2019)	Dorset County Council	July 2017	3 years
Paul Higgs (until September 2019)	The Royal Bournemouth and Christchurch Hospitals Volunteers	October 2016	3 years
Paul Hilliard	Bournemouth, Christchurch and Poole (BCP) Council	August 2019	3 years
Andrew Kerby	Dorset County Council	July 2019	3 years
Mufeed Ni'man (re-appointed September 2019)	NHS Dorset Clinical Commissioning Group	December 2016	3 years

Rae Stollard (until May 2019)	Bournemouth Borough Council	December 2016	3 years
Stephen Tee (re-appointed September 2019)	Bournemouth University	September 2015	3 years

As at 31 March 2020 there were the following vacancies on the Council of Governors:

- Medical and Dental - One vacancy
- Allied Health Professionals, Scientific and Technical - One vacancy

Meetings of the Council of Governors

The Council of Governors meets four times each year, usually in February, April, July and October and at other times as necessary. The first part of the meeting is open to the public. Against each name in the table below is shown the number of meetings at which the governor or director was present and in brackets the number of meetings that the governor or director was eligible to attend. The 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	Constituency, class or appointing organisation	Attendance
David Moss	Chairperson		4 (4)
Judith Adda	Governor	Bournemouth and Poole	0 (2)
Richard Allen	Governor	Christchurch and Dorset County	3 (4)
Colin Beck	Governor	Christchurch and Dorset County	2 (2)
Catherine Bishop	Staff Governor	Admin, Clerical and Management	3 (4)
Michael Bowen	Appointed Governor	The Royal Bournemouth and Christchurch Hospitals Volunteers	1 (2)
Tracy Broom	Governor	New Forest and Rest of England	0 (2)
Derek Chaffey	Governor	Christchurch and Dorset County	4 (4)
Lucy Darke	Staff Governor	Nursing, Midwifery and Healthcare Assistants	0 (2)
Howard Fincher	Governor	Bournemouth and Poole	2 (2)
Eric Fisher	Governor	Christchurch and Dorset County	4 (4)
Nick Harrison	Governor	New Forest and Rest of England	3 (4)
Paul Higgs	Appointed Governor	The Royal Bournemouth and Christchurch Hospitals Volunteers	2 (2)
Paul Hilliard	Appointed Governor	Bournemouth, Christchurch and Poole (BCP) Council	3 (3)

Marjorie Houghton	Governor	Bournemouth and Poole	3 (4)
Mark Howell	Governor	Bournemouth and Poole	0 (2)
Louise Johnson	Staff Governor	Allied Health Professions, Scientific and Technical	2 (3)
Andrew Kerby	Appointed Governor	Dorset County Council	1 (3)
John Lewis	Governor	New Forest and Rest of England	2 (2)
Keith Mitchell	Governor	Bournemouth and Poole	3 (4)
Mufeed Ni'man	Appointed Governor	NHS Dorset Clinical Commissioning Group	1 (4)
Susan Parsons	Governor	Bournemouth and Poole	4 (4)
Roger Parsons	Governor	Bournemouth and Poole	2 (2)
Markus Pettit	Staff Governor	Estates and Ancillary	1 (4)
Alan Radley	Governor	Bournemouth and Poole	1 (1)
Kevin Steele	Governor	Christchurch and Dorset County	2 (2)
Rae Stollard	Appointed Governor	Bournemouth Borough Council	1 (1)
Petrina Taylor	Staff Governor	Nursing, Midwifery and Healthcare Assistants	2 (2)
Stephen Tee	Appointed Governor	Bournemouth University	3 (4)
Maureen Todd	Governor	Bournemouth and Poole	4 (4)
David Triplow	Lead Governor	Bournemouth and Poole	4 (4)
Michele Whitehurst	Governor	Bournemouth and Poole	4 (4)
Sandy Wilson	Governor	New Forest and Rest of England	3 (4)
Brian Young	Governor	Christchurch and Dorset County	3 (4)

Name	Role	Attendance
Karen Allman	Director of Human Resources	3 (4)
Pankaj Davé	Non-Executive Director	2 (4)
Debbie Fleming	Interim Joint Chief Executive	2 (4)
Peter Gill	Director of Informatics	0 (4)
Christine Hallett	Non-Executive Director	3 (4)
Alexander Jablonowski	Non-Executive Director	1 (4)
John Lelliott	Non-Executive Director	1 (4)
Alyson O'Donnell	Medical Director	2 (4)

Pete Papworth	Interim Joint Director of Finance	1 (4)
Iain Rawlinson	Non-Executive Director	1 (4)
Richard Renaut	Chief Operating Officer	3 (4)
Cliff Shearman	Non-Executive Director	0 (4)
Paula Shobbrook	Director of Nursing and Midwifery	2 (4)

Elections

Elections were held in three public constituencies and two staff classes during the year. Efforts to maximise nominations included contacting members and articles in local newspapers, staff publications and on the Trust's intranet and meetings were held prior to nomination. Two of the public constituency elections were contested. One of the staff class elections was contested. There were no candidates for one staff class and therefore the vacancy is held. The elections to the Council of Governors were held in accordance with the Constitution.

Membership and Engagement

During 2019/20 membership engagement has been focused on broadening the range of engagement activities with the public enabling information to be shared about changes to local hospital services and health topics and to gain feedback from patients and relatives about their experiences at our hospitals. Individual governors also presented to a variety of community organisations, including a series of talks in local libraries and stands at community events as well as the Trust's Open Day and Patient Safety and Quality Improvement Conference. Staff governors visited different areas of the Trust to speak to staff and understand what they liked about working in the hospitals and what could be improved. Feedback from members of the public and staff was presented to the board of directors and the executive management team.

Regular emails and the membership newsletters have kept members up to date with news and events throughout the year.

Led by its Engagement Committee, governors continued to develop strategies to reach groups that are currently underrepresented geographically or demographically in the membership such as working age adults and younger members, engaging a university student to research how best to engage with young people, including a survey of students at local schools.

Over the next 12 months the governors will:

- continue local meetings in each of the public constituencies whether these are to provide information, engage with members or for consultation;
- continue to hold 'listening events' on the hospital site and out in the community;
- will hold joint public events with governors at Poole Hospital NHS Foundation Trust.
- continue to identify ways to engage with young people including working with local schools;
- provide more information in the FT Focus and in regular emails to members who have provided their email address about governors' activities;
- develop the governor and member pages on the Trust's website to provide more information to members and the public; and
- try to increase the awareness and understanding of members and the local community of the role of the governors and the benefits of foundation trust membership.

The Membership Engagement Strategy set a recruitment target of 300 new public members for 2019/20 and the performance against that target is shown in the table below.

Public constituency members	Last year (2019/20)	Next year (2019/20) (estimated)
At year start (1 April)	9998	9906
New members	346	300
Members leaving	438	500
At year end (31 March)	9906	9706

Staff constituency members	Last year (2019/20)	Next year (2019/20) (estimated)
At year start (1 April)	4600	4717
New members	859	500
Members leaving	742	500
At year end (31 March)	4717	4717

Analysis of membership in constituencies (as at 31 March 2020)

Public		Staff	
Bournemouth and Poole	6998	Medical and Dentistry	451
Christchurch and Dorset County	2082	Allied Healthcare Professionals, Scientific and Technicians	884
New Forest and Rest of England	826	Nursing, Midwifery and Healthcare Assistants	1934
		Administrative, Clerical and Management	1047
		Ancillary Services and Estates	401

Analysis of current public membership (as at 31 March 2020)

As at 31 March 2020, there were public members in the following demographic groups:

Analysis of current membership		
Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	2	137,323
17-21	344	41,487
22+	8,377	599,099
Ethnicity:		
White	9,244	714,637
Mixed	81	9,507
Asian or Asian British	155	14,175
Black or Black British	32	3,208
Other	26	2,514

Socio-economic groupings*:		
AB	3,211	80,328
C1	2,954	111,247
C2	1,905	79,750
DE	1,819	76,291
Gender		
Male	3,868	383,917
Female	6,006	393,991

Notes

- The analysis section of this report excludes 1,183 public members with no dates of birth, 368 members with no stated ethnicity and 32 members with no gender.
- Members of staff on fixed term or temporary contracts who have been continuously employed by the Trust for at least twelve months are eligible to become members of the staff constituency.
- Socio-economic data should be completed using profiling techniques (eg: postcode) or other recognised methods. To the extent socio-economic data is not already collected from members, it is not anticipated that NHS foundation trusts will make a direct approach to members to collect this data.
- The population data used to calculate 'Eligible membership' in the table above may differ as a result of using the most reliable source for this data. This may lead to variations in the total of eligible members provided under each section of the table, primarily due to the currency of the data. The 'Eligible membership' includes the Bournemouth, Christchurch, Poole and Dorset County public constituencies only and does not include the New Forest and Rest of England constituency data as the Rest of England element means there will be no corresponding baseline/eligible membership figures.

Members who wish to communicate with their governors should contact:

Governor and Membership Manager (B28)
The Royal Bournemouth and Christchurch
Hospitals NHS Foundation Trust
Castle Lane East
Bournemouth
BH7 7DW

or email: **ftmembers@rbch.nhs.uk.**

Email addresses for individual governors are also available on the Trust's website.

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 liability to pay interest as a result of not paying any invoices within 30 days.

NHS payables

	Number	Value
Invoices paid within 30 days	3,293	24,249
Invoices due to be paid within 30 days	3,699	19,498
Proportion of invoices paid within 30 days	89.0%	80.4%

Non-NHS payables

	Number	Value
Invoices paid within 30 days	69,032	154,617
Invoices due to be paid within 30 days	72,067	163,733
Proportion of invoices paid within 30 days	95.8%	94.4%

References to 30 days include the due date if later.

NHS Improvement's well-led framework

The board of directors has approved a leadership strategy that supports the delivery of the Trust's mission and strategic objectives as a well led organisation that delivers safe, high quality patient care that is clinically and financially sustainable. Through the strategy the board will oversee the creation of the leadership capabilities and leadership culture the organisation needs to possess in order to achieve its vision through the development of a leadership strategy. The leadership model for culture change will be one of collective leadership which will be clinically led. The board will promote the development of an inclusive leadership and management style. 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 was introduced in 2014 together with some new roles: Directors of Operations and Heads of Nursing and Quality for each care group and Matrons and Directorate Managers at directorate level. In 2017, the Trust reviewed these structures further with a view to strengthening the clinical leadership model and embedding the triumvirate approach through care groups. By triumvirate we mean the three way partnership between the manager, the lead nurse or allied health professional and the lead doctor. This led to the introduction of a care group medical lead in each care group. The triumvirate take a collective responsibility for the delivery of services in their area and this is replicated at all leadership levels in the Trust. Leadership development programmes are provided for each of these groups.

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

Private patient income

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

Board's responsibility for the Annual Report and Accounts

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

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

The accounts must provide a true and fair view and comply with International Financial Reporting Standards and the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20. In preparing the annual report and accounts, the directors are required to:

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

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

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

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

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

The Proposed Merger

The Boards of Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch NHS Foundation Trust have announced their intention to merge the operations, assets and liabilities of both into a single new trust. Whilst the Trust may therefore not be a going concern due to its planned dissolution during the next 12 months, the financial statements of the Trust have been prepared on a going concern basis because its services will continued to be provided by the successor Foundation Trust.

Debbie Fleming, Interim Joint Chief Executive, 24 June 2020

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.
There were 499 formal complaints received by the Trust for 2019/20, which is an increase on the previous years (426 complaints received in 2018/19, 310 complaints received in 2017/18, 293 complaints received in 2016/17).

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

Environment	8	2%	0	0%	0	0%
Infection Control	1	0%	2	0%	4	1%

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

Complaint outcomes

There were 499 formal complaints reported into the Trust with appropriate apologies offered in the letter of response from the Chief Executive. Directorates are required to follow through changes resulting from upheld complaints within their own risk and governance meetings, recording these and reporting them into their governance meetings.

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

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

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

Changes resulting from Complaints

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

You said “He needs his medication, he can’t say if he is in pain. Why was this not given to take home?”
We did “apologise and explained an adverse incident form has been raised, investigated and discussed with the staff nurse, additionally this learning was fed back to the AMU nursing team.”

You said “My elective operation has been cancelled and I had organised childcare and made arrangements for my recovery after surgery.”
We did “Explained sometimes owing to circumstances outside of our control and to ensure safety and wellbeing, we may have to postpone operations. Operational pressures such as availability of beds can be a factor and patients requiring emergency surgery, who take a priority over patients having elective procedures. We aim to improve communication with patients having elective surgery to align their expectations and fully inform them of this.”

You said "We gave you a dressing containing latex which you have an allergy to (patient declined to wait to see a doctor and asked an HCA for a plaster before leaving) "
We did "Reviewed stores to ensure there were no products containing latex. An alternative latex dressing has been procured. Safe, locked storage is being sourced for any products that contain latex"

You said "I requested to have surgery for a long standing debilitating illness in the hopes that this would improve their symptoms and make their condition more manageable."
We did "The appropriateness of surgery was discussed with Surgeons and Gastroenterologists involved in the care of the patient on a number of occasions. Surgery is not undertaken unless it will improve the condition and in this case it was decided that a medication change would be a more appropriate form of treatment."

You said "Patient has been put onto the wait list for surgery and informed that the current wait is approximately 6 months. Patient questioned "is there anything I can do to speed up the process, I thought there was a legal right to surgery within 18 weeks"
We did "Explained the NHS 18 week guidelines and that the patient's pathway had been reviewed by a Consultant and the patient was considered "routine". Explained the steps that the Trust is taking to reduce the waiting times"

Referrals to the Parliamentary and Health Service Ombudsman

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

After receiving a response from the Trust, complainants are advised to contact the PHSO if they remain unhappy. In 2019/20 12 cases were investigated by the PHSO with one partially upheld, one not upheld, six PHSO did not investigate and four cases are still in progress. This shows a slight decrease in the number taken to the PHSO and a decrease in the number upheld.

Stakeholder relations

A number of stakeholder engagement outcomes were identified by the Board of Directors and the Council of Governors to implement the recommendations from its external well-led review. These outcomes support the delivery of the Trust's strategic objectives and are in addition to existing contacts with social care and safeguarding teams in local authorities as part of the day-to- day operation of the hospitals and the participation of local authorities on the Council of Governors through their representatives.

Examples of stakeholder engagement include participation of the Chairperson and Chief Executive in the system leadership team for the Our Dorset integrated care system which includes local authorities, Executive Directors attending a range of boards and groups, which oversee the delivery of NHS England mandates, and the strategic intentions set out in the Dorset Sustainability and Transformation Plan. The Health and Social Care Overview and Scrutiny Committee for Borough of Poole and Bournemouth Borough Council's Health Overview and Scrutiny Committee have had sight of the Trust's Quality Report and have been offered the opportunity to comment as well as receiving an update during the year. The Trust's Chief Executive, Medical Director and other staff also attended meetings of local authority health overview and scrutiny committees and council meetings in Dorset to speak about the changes to local health services and the benefits for patients and the local population in Dorset.

As an example of this, the Trust was part of a successful NHS bid, led by Dorset Healthcare University NHS Foundation Trust, to provide the Integrated Urgent Care Service (IUCS) for Dorset, together with Dorset County Hospital NHS Foundation Trust, Poole Hospital NHS Foundation Trust and South Western Ambulance Service NHS Foundation Trust. To support this, the Trust, in collaboration with local GPs, developed the Urgent Treatment Centre (UTC) at the Royal Bournemouth Hospital. The service incorporates the Improved Access to GPs Service (IAGPS), meets the national criteria for an Urgent Treatment Centre and supports the streaming of patients away from the Emergency Department if their clinical condition does not require that type of treatment. From April 2019 the UTC supported the Dorset wide IUCS which incorporates both the GP Out Of Hours (OOH) service and the NHS 111 service..

In the last year the NHS has developed a new GP infrastructure – Primary Care Networks (PCN) and we have been working closely with the Bournemouth and Christhcurch PCNs particularly in responding to the COVID19 epidemic.

In the Urgent Treament Centre and within wider primary care, we have seen the rapid adoption of technologies that avoid the need for patients to seen face to face , including and much stronger use of telephone and video consultation.

Patient engagement

Key improvements in patient care have been centred both around structured and direct interventions, which positively impact on all aspects of quality. 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.

We recognise that staff can provide the best care by stepping back and seeing the experiences through the patient's eyes and is included in our quality improvement projects. The 'Point Of Care Foundation' trained a cohort of staff at the Trust and Poole Hospital NHS Foundation. This bespoke

training programme has been endorsed by NHS England who subsequently facilitated the training to be delivered to a further 60 partners in 'Our Dorset' Integrated Care System.

Staff across 'Our Dorset' are available to help to expand our inclusion of patients through use of:

- filmed patient interviews
- emotional and process mapping
- patient shadowing
- patient stories
- Modified co-design

Positive feedback is also received and shared with other trusts to help improve services and care for other patients. Compliments are collated through an eform and themed. Feedback is also shared with staff through #ThankYou!, an initiative focusing on recognising the huge amount of positive feedback we receive about our staff.

Various audits and surveys are undertaken throughout to the year to review current practice and identify challenges and areas for improvement. Feedback has been obtained through the Friends and Family Test, Care Conversations to obtain real-time patient feedback, local audits, national inpatient survey, national urgent and emergency care survey, national cancer care survey, Patient Advice and Liaison Service and complaints, LERN (Learning Event Report Notification) and other Share to Care forms, Freedom to Speak Up Guardian and Ambassadors, #ThankYou!, patient opinion and Healthwatch Dorset.

Care Conversations have been used to inform staff when making staffing template decisions through the One Acute Network. This qualitative method of obtaining feedback is vital to fully understand our patients experience.

Public engagement

The Trust and its healthcare partners have continued with engagement activity, led by NHS Dorset Clinical Commissioning Group, to explain the changes happening to healthcare services in Dorset.

Regular staff briefings take place at the Royal Bournemouth, Christchurch and Poole Hospitals led by our Joint Chief Executive and Joint Chair. These sessions provide 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. The Joint Chair also hosts smaller, more informal question and answer sessions for all staff.

Details of the engagement activities under taken by the governors are set out in the Governors' Review of the Year and in the section about the Council of Governors in the Accountability Report under 'Membership and engagement'. The Trust also holds a number of Understanding Health talks during the year and an annual Trust Open Day, which are open to the public.

Open Day - Over 3,000 visitors attended the 2019 RBH annual Open Day, three times more than the previous year.

Visitors were invited to learn CPR, attend a teddy bear clinic or take part in a range of health checks including blood pressure, sight and balance. Hospital departments and partner organisations like the Dorset Police and the fire service attended and Dorset and Somerset Air Ambulance also stopped by giving hundreds the chance to have a look inside and talk to the pilot.

A new link up with the Arts University, Bournemouth (AUB) proved to be a huge success with AUB students designing artwork that were dispersed in the different coloured zones around the hospital. Departments also offered tours and plans for the future of the hospital were also on display.

Understanding Health Events – Free Understanding Health talks took place last year covering the topics of Understanding Blood, Understanding Epilepsy and Understanding Sepsis. The Sepsis talk was repeated at a local business after a request from a staff member and extremely positive feedback was received.

£147 million engagement events - Around 1,000 people attended the public engagement events at RBH and PH in June which focused on the £147m investment across the hospitals. The two day event was promoted extensively to staff and the public via local media, social media as well as via a leaflet drop to thousands of households close to the hospitals. MPs and local businesses were also invited and encouraged to share their opinions on the plans.

Christchurch Hospital Consultation Events - Over 600 staff and local residents attended a public exhibition in January 2020 to view the proposed plans for the future of the Christchurch Hospital site which included the new Macmillan Unit. The three day event started with a staff event and then opened up to the general public and encouraged feedback on the different aspects of the designs.

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

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

Events Social Media - Social media platforms have been used more than ever over the last year to update the public and staff with Trust news and changes. The Trust Facebook page has over 7.6k likes and 7.3k followers on Twitter. Increasingly people want to ask questions or share an experience with us in this way. Direct messages through social media are answered during working hours and the platforms are a great way of engaging with the public.

CEO video updates - CEO Debbie Fleming has given a number of video updates throughout the year. Mainly aimed at staff, the You Tube videos are promoted via the intranet.

Remuneration Report

Annual statement on remuneration

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

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

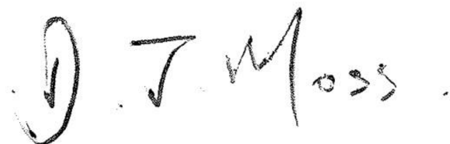
Non-Executive Director's remuneration and terms and conditions of service are developed and reviewed periodically by the Council of Governors NED Nomination and Remuneration Committee and ratified by the Council of Governors.

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

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

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

Debbie Fleming, Interim Joint Chief Executive, 24 June 2020



David Moss
Chairman, 24 June 2020

Senior manager remuneration

Senior manager remuneration											
Name	Title	2019/20					Restated 2018/19				
		Salary and Fees	Other Remu-neration	Total Salary and Fees	Pension Related Benefits	Total	Salary and Fees	Other Remu-neration	Total Salary and Fees	Pension Related Benefits	Total
		(bands of £5000) £'000	(bands of £5000) £'000	(bands of £5000) £'000	(bands of £2,500) £'000	(bands of £5,000) £'000	(bands of £5,000) £'000	(bands of £5000) £'000	(bands of £5000) £'000	(bands of £2,500) £'000	(bands of £5,000) £'000
Executive Members											
Mr A Spotswood	Chief Executive (See note 1)	0	0	0	0	0	151 - 155	261 - 265	411 - 415	0	411 - 415
Mrs D Fleming	Interim Joint Chief Executive (see note 2)	101 - 105	0	101 - 105	0	101 - 105	21 - 25	0	21 - 25	0	21 - 25
Mrs P Shobbrook	Director of Nursing and Midwifery	146 - 150	0	146 - 150	80 - 82.5	226 - 230	135 - 140	0	135 - 140	105 - 107.5	246 - 250
Mr P Papworth	Interim Joint Director of Finance (See note 4)	106 - 110	0	106 - 110	0	106 - 110	135 - 140	0	135 - 140	0	135 - 140
Mr R Renaut	Chief Operating Officer	136 - 140	0	136 - 140	30 - 32.5	166 - 170	131 - 135	1 - 5	135 - 140	10 - 12.5	146 - 150
Mrs K Allman	Director of Human Resources	121 - 125	0	121 - 125	12.5 - 15	130 - 135	116 - 120	0	116 - 120	0 - 2.5	121 - 130
Dr A O'Donnell	Medical Director (See note 5)	186 - 190	0	186 - 190	0	186 - 190	181 - 185	0	181 - 185	0	181 - 185
Mr P Gill	Director of Informatics (See note 6)	61 - 65	0	61 - 65	7.5 - 10	70 - 75	66 - 70	0	66 - 70	42.5 - 45	111 - 115
Board Member											
Ms N Hartley	Director of Organisational Development (see note 7)	0	0	0	0	0	16 - 20	0	16 - 20	Not applicable	16 - 20
Non-Executive Members											
Mr D Moss	Interim Joint Chairperson (See note 8)	26 - 30	0	26 - 30	Not applicable	26 - 30	46 - 50	0	46 - 50	Not applicable	46 - 50
Mr C Shearman	Non-Executive Director (See note 10)	11 - 15	0	11 - 15	Not applicable	11 - 15	11 - 15	0	11 - 15	Not applicable	11 - 15
Mr DI Rawlinson	Non-Executive Director (See note 11)	11 - 15	0	11 - 15	Not applicable	11 - 15	11 - 15	0	11 - 15	Not applicable	11 - 15
Ms C Hallett	Non-Executive Director	16 - 20	0	16 - 20	Not applicable	16 - 20	16 - 20	0	16 - 20	Not applicable	16 - 20
Mr J Lelliott (OBE)	Non-Executive Director	16 - 20	0	16 - 20	Not applicable	16 - 20	16 - 20	0	16 - 20	Not applicable	16 - 20
Mr A Jablonowski	Non-Executive Director	16 - 20	0	16 - 20	Not applicable	16 - 20	16 - 20	0	16 - 20	Not applicable	16 - 20
Mr P Davé	Non-Executive Director (See note 13)	11 - 15	0	11 - 15	Not applicable	11 - 15	6 - 10	0	6 - 10	Not applicable	6 - 10
Band of highest paid director				201 - 205					201 - 205		
Median Total Remuneration				28,891					29,608		
Ratio				7.0					6.8		

Notes:

1 Mr A Spotswood concluded his post as Chief Executive on 31st December 2018 and previously opted out of the pension scheme on 31 March 2017. The other remuneration shown in 2018/19 represents his contractual termination payment. Poole Hospital NHS Foundation Trust contributed 50% of this contractual termination payment as part of the agreed interim joint management arrangements which is not reflected in the numbers above.

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

4 Mr P Papworth was appointed to Interim Joint Director of Finance on 1st October 2019 having previously opted out of the pension scheme on 31st May 2017. The salary shown represents the Trust's 100% contribution from 1st April 2019 to 30th September 2019 and 50% contribution from 1st October 2019 after adjusting for the recharge to Poole Hospital NHS Foundation Trust for the remaining 50%.

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

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

7 Ms N Hartley concluded her post as a Board member on 30 June 2018.

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

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

11 Mr DI Rawlinson commenced his post as Non Executive Director on 1 October 2017

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

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

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

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

No individual named above received any benefit in kind during either financial year.

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

Of the 16 senior managers in the table above, 10 received expenses during the year amounting to a total of £10,407 after contributions from Poole Hospital NHS Foundation Trust. In 2018/19 11 received expenses amounting to £10,504 after contribution from Poole Hospitals NHS FT.

There are 23 governors (excluding staff governors), of which 8 received expenses during the year amounting to a total of £3,303.29. In 2018/19 6 governors received expenses amounting to £2,624.

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

All Executive Directors are required to provide six months' written notice, however in appropriate circumstances this could be varied by mutual agreement.

With the exception of the Interim Joint Chairperson, Interim Joint Chief Executive and Interim Joint Director of Finance, all senior manager contracts are permanent. Mr D Moss and Mr P Papworth hold permanent contracts with the Trust and interim contracts with Poole Hospital NHS Foundation Trust. Mrs D Fleming holds an interim contract with the Trust with her permanent contract held by Poole Hospital NHS Foundation Trust.

All senior managers appointed on a permanent contract are required to provide three months' written notice.

There are no payments for loss of office other than standard NHS redundancy provisions.

Median Total Remuneration

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

The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. The March payments have been annualised and adjustments made for any outliers that would distort the results. Agency costs have been excluded from this calculation.

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

Senior manager pension entitlements							
Name	Title (as at 31 March 2020)	Real Increase in Pension and Related Lump Sum at retirement age	Total accrued Pension and Related Lump Sum at retirement age at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019 (Inflated)	Real Increase in Cash Equivalent Transfer Value	Employer-Funded contribution to growth in CETV for the year
		(Bands of £2,500)	(Bands of £5,000)	£'000	£'000	£'000	£'000
Mrs D Fleming	Interim Joint Chief Executive (see note 2)	N/A	N/A	N/A	N/A	N/A	N/A
Mrs P Shobbrook	Director of Nursing and Midwifery	10 - 12.5	206 - 210	1,081	983	98	77
Mr P Papworth	Interim Joint Director of Finance (see note 3)	N/A	N/A	N/A	N/A	N/A	N/A
Mr R Renaut	Chief Operating Officer	0 - 2.5	126 - 130	661	618	43	23
Mrs K Allman	Director of Human Resources	5 - 7. 5	96 - 100	589	543	46	28
Mr P Gill	Director of Informatics	0 - 2.5	136 - 140	789	751	38	20
Dr A O'Donnell	Medical Director (see note 4)	N/A	N/A	N/A	N/A	N/A	N/A

Senior manager pension entitlements

Notes:

1. Non Executive Directors do not receive pensionable remuneration, and as such, there are no entries in respect of pensions for Non Executive Directors.

2. Mrs D Fleming commenced her post as Interim Joint Chief Executive (with Poole Hospital NHS Foundation Trust) on 1st January 2019 and has opted out of the pension scheme.

3. Mr P Papworth commenced his post as Interim Joint Director of Finance (with Poole Hospital NHS Foundation Trust) on 1st October 2019 and opted out of the pension scheme on 31 May 2017.

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

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05

the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated as prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Debbie Fleming, Interim Joint Chief Executive, 24 June 2020

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 on page 53. They do not receive any other payments from the Trust.

Service Contract Obligations

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

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

Policy on payment for Loss of Office

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

Trust's Consideration of Employment Conditions

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

Service Contracts

All executive directors are employed on permanent or fixed term contracts

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

Trust Board Members

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

Remuneration Committee

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

Nomination and Remuneration Committees

The Nomination and Remuneration Committee is a committee of the board of directors with responsibility for:

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

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

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

The committee determined that a pay increase from 1 April 2019 was to be made to executive directors pay during the year. The committee noted the process and remuneration to appoint a Joint Interim Finance Director for the Trust and Poole Hospital NHS Foundation Trust in line with plans to merge the two Trusts and establish a Shadow Interim Board of Directors from December 2019. The committee also reviews the balance of skills, knowledge and experience on the board of directors when considering the appointment of an executive director or when a vacancy arises for a non-executive director rather than annually as set out in paragraph B.2.3 of the NHS Foundation Trust Code of Governance.

The table below sets out the members of the committee during 2019/20 and the number of meetings at which each director was present and in brackets the number of meetings that the director was eligible to attend.

Name	Meetings attended by virtual approval
David Moss, Chair	2/2
Christine Hallett, Senior Independent Director	2/2
Pankaj Dave	2/2
John Lelliott	2/2
Alex Jablonowski, Vice Chair	2/2
Cliff Shearman	2/2
Iain Rawlinson	2/2

The Chief Executive is a member of the committee for decisions relating to the appointment or removal of executive directors only.

No independent consultants, who materially assisted either of the committees in their consideration of any matter, were engaged to provide advice or services to the Nomination and Remuneration Committee or the Non-Executive Director Nomination and Remuneration committee during the year under report.

NED Nomination and Remuneration Committee

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

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

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

There were four meetings of the committee during this financial period, and the members' attendance is set out below:

Name	Meetings attended out of possible total
David Moss, Chair	3 / 4
Christine Hallet, Senior Independent Director *(replaced David Moss for one meeting only)*	1 / 1
David Triplow, Lead Governor	4 / 4
Keith Mitchell, Deputy Lead Governor	2 / 4
Eric Fisher, Public Governor	3 / 4
Sue Parsons, Public Governor	4 / 4
Sandy Wilson, Public Governor	4 / 4

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

Disclosures required by Health and Social Care Act

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

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

Staff report

Informing and consulting with our staff

A number of areas have been reconfigured during the year, either to accommodate different ways of working or changes to location, including consultation to bring together The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospitals NHS Foundation Trust senior staff within Care Groups and critical day one posts for the new organisation.

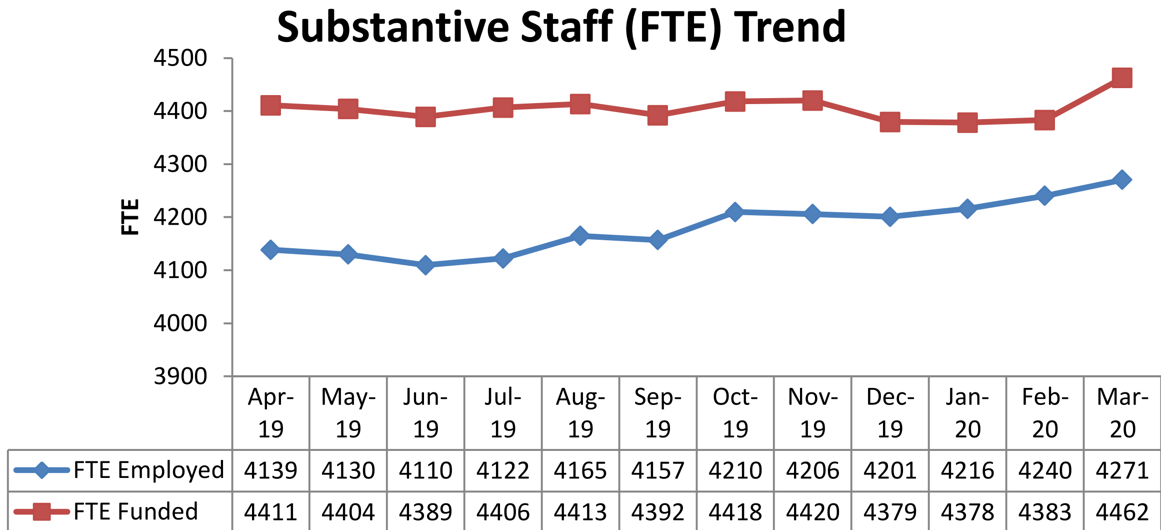
In accordance with the Trust's Organisational Change Policy, staff have been properly consulted with and given the opportunity to comment and/or make alternative suggestions.

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

Consultation	Number of staff affected	Date
Royal Voluntary Services (RVS) TUPE – Following TUPE consultation 12 catering staff from RVS transferred to the Trust with effect from the 1st October 2019.	12	August 2019 to October 2019
Ward Changes – Ward 7 and 14 – To amalgamate Ward 7 (Orthopaedics) and Ward 14 (Vascular). As from the 2nd September 2019 it was planned that the two wards will become one 21 bedded ward with a mixture of vascular and orthopaedic patients. During the consultation process there was a change with the proposed plan, Ward 14 closed and Ward 7 turned into two sides, Ward 7 left was for Orthopaedic patients and Ward 7 right was for Vascular patients.	62	June 2019 to August 2019
Department of Sexual Health - On going consultation, moving local sexual health services into a hub that will potentially be based in the Boscombe area.	33	On-going
Stroke – To reconfigure the Stroke Units at Bournemouth and Poole Hospitals into one unit with different specialities at each unit.	125	September 2019 to October 2019
Band 1 Closure – As Band 1 will be closing nationally to all new recruits all staff who are currently Band 1's at the Trust were consulted with and asked to confirm their preference in terms of either staying on Band 1 or moving across to Band 2.	226	April 2019 to March 2020
Discharge Coordination team – Instead of sitting in a central team the nursing and support staff will move out to the Wards with three people left to work from a central team	7	July 2019 to August 2019
Merger – Bringing together Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust as one larger Trust which will be called University Hospitals Dorset NHS Foundation Trust. This process commenced with Tier 1 which was the creation of the Shadow Interim Board consisting of 7 Non-Executive and 7 Executive Directors. Tier 2 then commenced in February 2020.	32	Tier 1 – September 2019 to November 2019 Tier 2 – February 2020 to March 2020

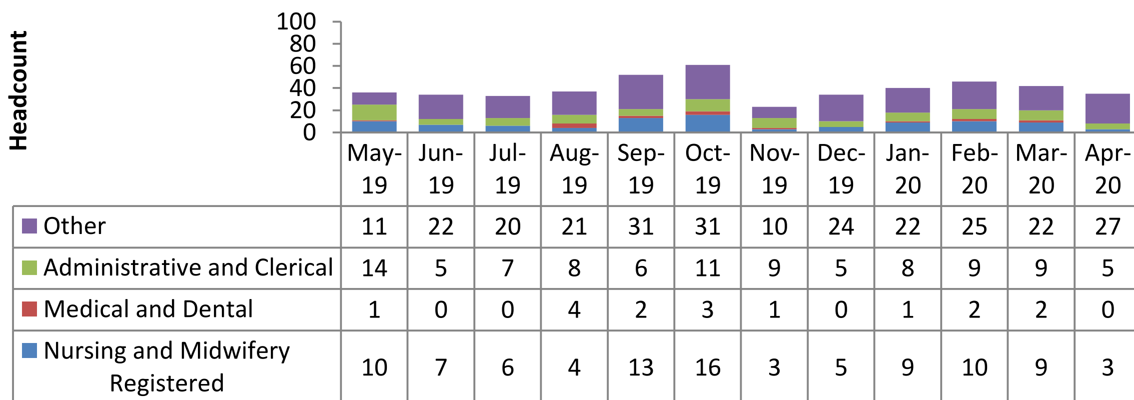
Staff Numbers

The increase in overall staff numbers is 132 between April 2019 and March 2020.
This decreases the vacancy gap by 60 FTE.



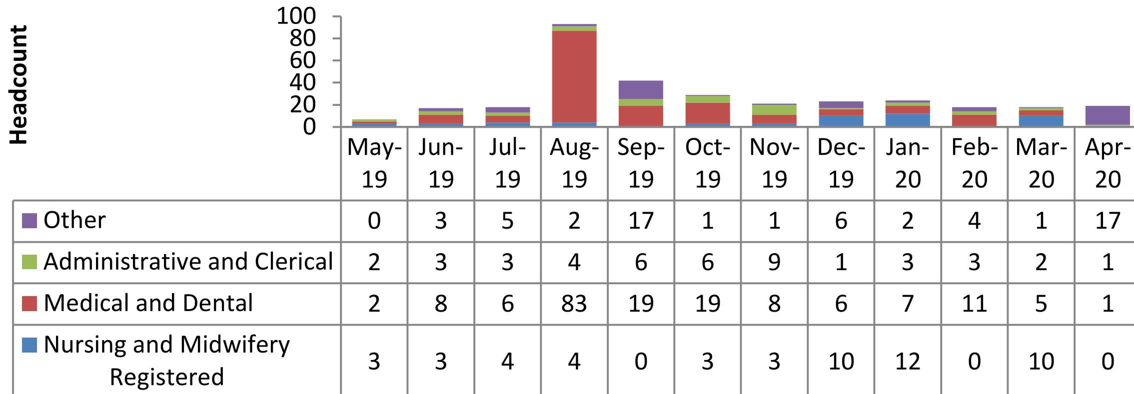
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
FTE Employed	4139	4130	4110	4122	4165	4157	4210	4206	4201	4216	4240	4271
FTE Funded	4411	4404	4389	4406	4413	4392	4418	4420	4379	4378	4383	4462

We have consistently recruited to our key vacancies throughout the period, with the normal increases during September and October, reflecting the intake of newly qualified nurses.



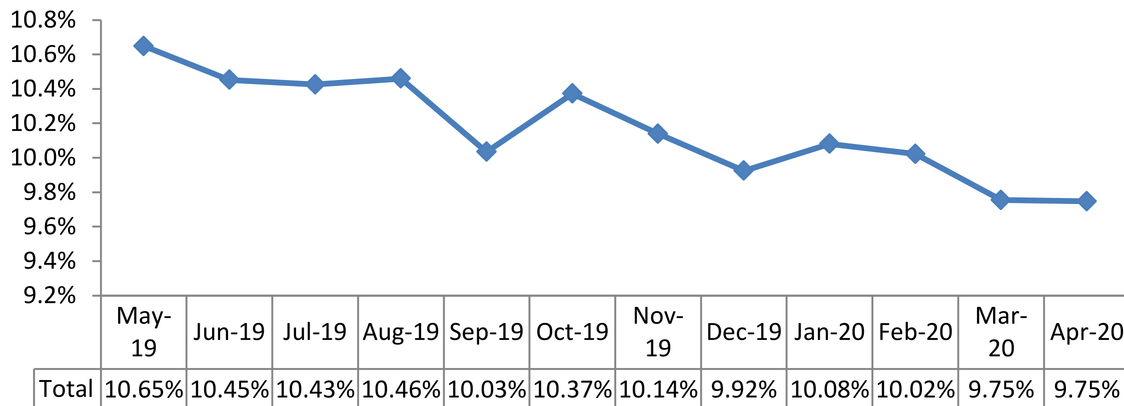
	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Other	11	22	20	21	31	31	10	24	22	25	22	27
Administrative and Clerical	14	5	7	8	6	11	9	5	8	9	9	5
Medical and Dental	1	0	0	4	2	3	1	0	1	2	2	0
Nursing and Midwifery Registered	10	7	6	4	13	16	3	5	9	10	9	3

The chart below highlights the temporary Medical and Dental appointments of our Junior Medical Staff rotations.



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Other	0	3	5	2	17	1	1	6	2	4	1	17
Administrative and Clerical	2	3	3	4	6	6	9	1	3	3	2	1
Medical and Dental	2	8	6	83	19	19	8	6	7	11	5	1
Nursing and Midwifery Registered	3	3	4	4	0	3	3	10	12	0	10	0

Turnover of staff has reduced during the previous 12 months by 0.90%



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Total	10.65%	10.45%	10.43%	10.46%	10.03%	10.37%	10.14%	9.92%	10.08%	10.02%	9.75%	9.75%

Gender split by staff grade

Grade	Male	Female
Board Director	9	5
VSM	3	3
Medical & Dental Consultant	159	83
Medical & Dental Non-Consultant Career Grade	100	63
Medical & Dental Trainee Grades	87	99
Band 9	2	2
Band 8d	3	8
Band 8c	3	12
Band 8b	23	30

Band 8a	41	67
Band 7	79	357
Band 6	117	607
Band 5	142	733
Band 4	69	269
Band 3	104	415
Band 2	249	823
Band 1	50	42
Other	4	8

Sickness absence data

Sickness absence data for 2019/20 is published by NHS Digital:
https://digital.nhs.uk/data-and-infomration/publications/statistical/nhs-sickness-absence-rates

Information on Counter Fraud

The Trust has an Anti-Fraud, Bribery and Corruption Policy in place which is endorsed by senior management and the Trust's audit committee. The Human Resources Department has strong links to the Counter Fraud team, who are invited to join a joint investigators group meeting twice a year to enable an exchange of best practice and closer working.
The Counter Fraud Team hosted a stand in the Atrium during Fraud awareness week in November 2019. Regular reminders are also included in staff communications to maintain vigilance.
Counter fraud also carries out reactive investigations and reports on the results of these investigations to the audit committee.

Exit packages / Settlement agreements

Within all large organisations there will be occasions when disputes take place between staff. The Trust has a number of measures to address these, including a robust reporting system, mediation, facilitated meetings, performance management, disciplinary processes and a formal grievance process. Occasionally it is not possible to resolve employment issues and consideration may be given to negotiating a settlement agreement, particularly if the case would be likely to escalate to an Employment Tribunal. This does not necessarily mean the Trust would have lost the case at Tribunal, but is usually undertaken on commercial grounds. In the past twelve months are have been the following settlement agreements:

Reason for settlement	Amount	Date
Performance and relationship issues (contractual payment only)	£14,034.40	May 2019
Unable to redeploy into suitable alternative employment (contractual payment only)	£4,812.07	August 2019
Performance and relationship issues (contractual payment only)	£12,704.75	November 2019
Performance and relationship issues (contractual payment only)	£27,977.13	December 2019

Information on Gender Pay Gap

Link to the Cabinet Office website https://gender-pay-gap.service.gov.uk

Staff policies and actions:

Occupational Health and Staff wellbeing

The Trust has a well-established and respected Occupational Health Department. The team consists of the following trained Occupational Health clinicians:

- Senior Nurse and physiotherapy Manager
- Occupational Health Physician I Specialist Nurse Practitioners I Physiotherapy Assessments
- Occupational Health Technicians - supported by an administrative team

The team is experienced in assisting employees who work in a variety of workplace settings with some very complex and sensitive issues. This includes advice on sickness absence and rehabilitation programmes to facilitate returns to work after sick leave and physiotherapy assessment.

The Trust also has an employee assistance programme in place as a benefit to employees that supports and enables them to manage personal and work related issues that may otherwise affect their wellbeing, motivation or productivity. Financial, legal and wellbeing advice is also available.

Health and wellbeing is one of the key components of the Trust's People Plan. We are aware of the need to ensure employees are kept fit and well and feel well enough and positive about coming to work. We also recognise the impact that this has on the quality of patient care and patient outcomes. There are many initiatives in the Trust to support this.

The Trust offers physiotherapy, circuit training, pilates and yoga classes, a running club, mindfulness sessions, personal resilience workshops, staff networks and groups, chaplaincy services and regular Schwartz Rounds for staff to talk openly and honestly about issues to matter to them. This plays a part in reducing staff sickness and in maintaining high staff engagement scores in the national NHS Staff Survey.

Continuing employment, training, career development and promotion of disabled persons/ employees

The Trust holds 'Disability Confident' accreditation. It takes positive and proactive steps to maintain continued employment, provide training, and foster career development and promotion for disabled members of staff.

In 2020/21 the Trust will be reporting in accordance with the 'Workforce Disability Equality Standard' (WDES). This national reporting standard includes providing statistics which demonstrate a proportionate comparison between disabled and non-disabled members of staff in relation to their experience at work and opportunities. This data will enable a gap analysis to be conducted and the development of a targeted action plan in conjunction with the Pro-Ability staff network. This network aims to listen, understand and support people living and working with physical disabilities and long term health conditions. The network is working closely with the HR department to understand the reasons for low declaration rates of disabilities and how this can be improved. This work has been particularly important during the Covid-19 pandemic.

The network is a member of the equality, diversity and inclusion committee, which is responsible for the monitoring and implementation of the action plan.

The Trust recognises there is a strong business case for adopting a positive approach to supporting and developing disabled staff both in terms of acquiring and maintaining valuable workplace skills. Developing a culture where both our staff and patients can flourish is simply the right thing to do.

It is the responsibility of the Human Resources team to maintain up-to-date Human Resources policies, taking into consideration revised employment law. All policies are discussed and agreed in partnership with Staff Side representatives. This year the following have been reviewed:

- Balancing Work and Family life
- Organisational Change

Going forward, following merger, all HR policies will be reviewed for the combined Trust. These are being drafted within the Merger Integrated Team.

The Trade Union

(Facility Time Publication Requirements Regulations 2019)

The Trust is required to provide the following information on a yearly basis, detailing the number of trade union officials, the time they spend on union business and costs

Relevant union officials

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*
34	30.48

Percentage of time spent on facility time

The amount of time employees who are relevant union officials spend on trade union work as a % of their working hours?

0%	18
1-50%	16
51%-99%	0
100%	0

Percentage of pay bill spent on facility time

Total cost of facility time	£11,863
Total pay bill	£217,882,043
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.0054

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

Staff engagement is at the core of our organisational development plan. This year we have extended our champions approach. We have developed Inclusion Champions who are made up from our Staff Network Group leads and allies. We have also created some joint Cultural Champions with our colleagues at Poole Hospital to help shape the culture and values we want for our new trust.

Our champions come from all different roles and departments across the two trusts to ensure we continue to listen to and empower our staff to make improvements to their services and ways of working. The champions lead focus groups, interview leaders, carry out "trolley-walks" and host our information hubs to get to those harder to reach groups. They use the information we gather from our local and national staff surveys on what it feels like to work here. Our board of directors is always keen to listen to the messages from the champions and to work alongside them in gathering data

NHS National Staff Survey

The NHS staff survey is conducted annually. The results are grouped into ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being an average of those.

The response rate to the 2019 survey amongst eligible trust staff was 47.8% (2018: 52.8%). Scores for each indicator together with that of the survey benchmarking group (Acute trusts) are presented below:

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

This year we were very pleased to score highest in our benchmarking group for the themes of Staff Engagement Immediate Managers, Morale, Safety Culture and Team working. We are also pleased to be working closely with Poole Hospital to develop a joint action plan ahead of our planned merger.

Future priorities and targets

We have identified that there is still work to be done on the theme Safe Environment – Violence, as this is the only theme that is not significantly better than our benchmarking group of Acute Trusts. The trust acknowledges that the number of staff who reported violence at work from patients or other members of the public has significantly increased.

We also need to focus on the visibility of our leaders. The trust did score significantly higher than the rest our benchmarking group of Acute Trusts on all four questions around senior managers. However, the percentage of staff who know who the senior managers are has fallen since 2018 to 86%. This can be partially explained for our most senior leaders by the increased focus on implementing merger and the CSR.

Diversity and Inclusion will continue to have a big focus in the year ahead (see the next section).

We are working closely with Poole on a joint action plan in response to 2019 and planning for our 2020 survey. It is likely that the national survey may take a slightly different format following the COVID-19 pandemic. We will also be mid-way through the survey preparation at the intended date of merger.

Embracing equality, diversity and inclusion

Over the last twelve months we have continued to make progress with the diversity and inclusion agenda into the day-to-day work of RBCH.

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

Our equality objectives 2018-2020

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

Our equality, diversity and inclusion committee has representation from across the organisation, including staff network leads and patient representatives. This committee provides the governance and assurance to the Trust Board on compliance with statutes and national standards and makes recommendations on specific interventions.

As we progress with the merger with Poole Hospital NHS Foundation Trust in October 2020 a new equality strategy and objectives will be developed by a joint committee. All our action plans and reporting will be aligned to ensure consistency for staff and patients across the newly formed organisation.

Working with others

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

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

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

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

In Summary

2020 is presenting unique challenges with the Covid-19 pandemic and the organisational merger in October 2020. To make sustained diversity and inclusion progress it is imperative we have the right level of leadership commitment and accountability at all levels, that everyone in the new organisation understands diversity and inclusion is "everybody's business".
We will continue to work with our staff, our patients and all stakeholders to ensure inclusion is at the heart of everything we do.

Equality, Diversity and Inclusion Committee

The Trust has an identified executive lead for diversity and has a well-established Equality and Diversity Committee which meets monthly and is attended by representatives from across the Trust, including senior managers, union representatives and governors. The committee reports to the Board's Workforce Strategy and
Development Committee and directly to the Board of Directors.

Purpose

- to ensure the Trust commits to an equality, diversity and inclusion agenda for the benefit of our patients and staff and in line with good practice and current legislation;
- to ensure the health needs of the diverse communities we serve are best met;
- to encourage and promote workplaces free from discrimination and where our diverse staff can flourish;
- to challenge the organisation and hold it to account where and when the above does not happen.

In summary:

To make sustained diversity and inclusion progress it is imperative that we have the right level of leadership commitment and accountability at all levels within the organisation. Diversity and inclusion is ‘everybody’s business’ and everyone in the Trust is therefore expected to take an active part, supported by the work of our specialist teams.

Our Board of Directors leads by example in relation to inclusive practice and our senior leadership team will focus on operational embedding of equality, diversity and inclusion to stimulate action and commitment to behaviour change.

NHS Foundation Trust Code of Governance

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

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

Debbie Fleming, Interim Joint Chief Executive, 24 June 2020

Annual Governance Statement 2019-20

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, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

The Trust's risk management strategy clearly defines these responsibilities and provides guidance for the fulfilment of these roles. This is underpinned by developing and supporting a culture that encourages an open and honest recording of risks and organisation-wide learning where risks are continuously identified, assessed and minimised. As Chief Executive, I sponsor the role of the Freedom to Speak Up Guardian, reports regularly to the Audit Committee and the Board of Directors to provide assurance around the reporting, safety and learning culture within the Trust as well as identifying key themes. The 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 6 monthly by the Board of Directors and quarterly by the Audit Committee to ensure that it is comprehensive and that the Trust's internal controls and risk management systems are operating effectively. The Trust uses a single risk register system and a standard risk register process. Risk mitigation is achieved through a continuous cycle of the identification, assessment, control and review of risk which supports our open and honest reporting culture. The Freedom to Speak Up Guardian reports quarterly to the Audit Committee and the Board of Directors to provide assurance around the reporting, safety and learning culture within the Trust as well as identifying key themes. The Audit Committee is also responsible for approving the Trust's speaking up policy.

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

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

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

The risk and control framework

Risk management strategy

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

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

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

The Board of Directors has reviewed the Trust's principal corporate and strategic objectives and identified mitigating strategies for any risks to the delivery of those objectives using the 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 Healthcare Assurance Committee, Finance and Performance Committee, Workforce Strategy and Development Committee, Infection Prevention and Control Committee, Medicines Governance Committee, Information Governance Committee, Emergency Preparedness Committee, Quality and Risk Committee and Health & Safety Committee. All risks entered onto the risk register are categorised according to the Trust risk management strategy using a standard risk matrix common to all healthcare providers and commissioners in Dorset. The risk rating value is a combination of likelihood and consequence. All risks are assigned a current risk score and a target risk score following implementation of action plans and mitigation. All action plans have a responsible lead and timeframe noted. All high and corporate level risks are also assigned an executive director lead.

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

Key risks

High risks (risks with a risk rating score of 12-25) on the Trust's risk register are routinely reviewed by the Healthcare Assurance Committee, which meets every other month. The Healthcare Assurance Committee is chaired by a non-executive director and membership includes representation from the Board of Directors and the Council of Governors. The Quality and Risk Committee also reviews all new clinical risks monthly ensuring escalation to the Healthcare Assurance Committee and Trust Management Board, as appropriate. The full 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 those risks alongside an in-depth review of those risks on a cyclical basis.

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

The principal risks to compliance with the condition 4 of the NHS foundation trust conditions set out in the Trust's provider license relate to the metrics set out in the appendices to the Single Oversight Framework as follows:

There is a risk that the impact of Covid-19 will provide significant challenges to key performance targets that will impact on our patients, such as cancer access times and referral to treatment targets.

The Trust continues to work with partners in the Dorset integrated care system to address these risks as well as through its own quality improvement projects. This includes implementation of the Clinical Services Review and the merger with Poole Hospital NHS Foundation Trust to ensure integration of clinical pathways and clinical and corporate services.

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.

Well-led reviews

An external review of the Board of Directors using the CQC's and NHS Improvement's well-led framework for leadership and governance reviews was undertaken in 2016/17. The Trust received a very positive report on the effectiveness of its governance arrangements, which rated the Trust in the highest 'Green' category in seven out of the ten domains and Amber-Green, the second highest rating in the remaining three domains. This review was supplemented by an internal facilitated review in 2017/18, again using the well-led framework, which showed that a similarly high standard of performance had been maintained. This reflected the work that had been undertaken to implement the recommendations from the external well-led review in 2016/17. In April 2018, the CQC undertook an assessment of the Trust using the latest joint well-led framework for leadership and governance published in June 2017 and the Trust received an overall rating of 'Outstanding' from the CQC for the well-led domain.

Public stakeholders

The Trust is in dialogue to actively manage risks with public stakeholders and a number of stakeholder engagement outcomes were identified by the Board of Directors and the Council of Governors to implement the recommendations from the external well-led review. Examples of this dialogue include:

- participation of the Chairperson and Chief Executive in the system leadership team for the integrated care system (ICS) for Dorset;
- the Chief Operating Officer attending the Urgent and Emergency Care Delivery Board for Dorset, which oversees delivery of NHS England/Improvement mandates and the strategic intentions set out in the Dorset Sustainability and Transformation Plan; and
- the Director of Nursing and Midwifery attending Dorset's Quality Surveillance Group, which is attended by representatives from NHS England/Improvement and the Trust's regulators. The Trust also undertakes monthly contract monitoring meetings with commissioners where quality, activity, performance, finance, patient safety and risk management reports are presented and discussed. The Trust is also party to a Dorset health system collaborative agreement with NHS Dorset Clinical Commissioning Group and the other NHS providers in Dorset.

Executive directors also present to the Council of Governors on a quarterly basis, including performance against the Trust's strategic objectives, highlighting risks to delivery of performance.

Governors also attend meetings of board committees where risks are discussed including the Audit Committee, Healthcare Assurance Committee and Workforce Strategy and Development Committee. The Council of Governors provides feedback to the Board of Directors based on its engagement with the public, patients and staff.

Workforce risks

In this year, the people functions have become increasingly aligned across Royal Bournemouth and Christchurch Hospitals and Poole Hospital in advance of merger. Although existing workforce governance structures and risk registers remain in each Trust, the main workforce risks are common and this has highlighted the value of working together and joining services to mitigate these risks. The benefits of implementing the Clinical Services review are already becoming apparent e.g. in Stroke services where critical skills and scarce resources are now being deployed to better effect.

Workforce plans continue to be developed in conjunction with medical, clinical, human resources, finance, corporate and operational group leads to build plans and templates, ensuring safe and high quality patient care. Focused workforce planning is taking place around service reconfiguration with the introduction of more sustainable workforce models, optimizing the use of critical skills and new roles. Other factors are supporting more sustainable workforce models including the application of technology with enabling workforce systems, improved rostering and flexible working practices.

The Workforce Committee and Board 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). Benchmarking plays a key part in this as both Trusts learn from each other in advance of merger and from other key measures including Model Hospital data.

The 3 year People Plan has, in its final year, continued to be the framework for people strategies and priorities, helping to support and inspire staff to deliver the best possible care for patients and attract and retain the best talent. The emphasis this year is moving towards the newly defined Joint People Plan for the merged trust. This ensures that effort is aligned behind common strategies, shared objectives and agreed integration plans to enable efficiencies and provide an employee experience and proposition of equally high quality and value across all sites.

The Medical Workforce Transformation Steering Group (TSG) and Premium Cost Avoidance TSG meetings have been key in driving performance against medical and nursing workforce metrics with reviews focused on financial and quality targets. Bank and agency usage continues to be under particular scrutiny and cross-trust sharing of good practice is increasing in advance of the merged Bank.

Allied health professional and healthcare scientist staffing is monitored and reviewed at a bi-monthly forum.

The Trust continues 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. National shortages of key medical, clinical and allied health professionals continue to be a priority for cross Dorset initiatives. The national Interim NHS People Plan, developed collaboratively with national leaders and partners, now provides a useful standard for how people working in the NHS should be supported to deliver care.

Compliance with national quality and staffing safeguards is 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 are monitored and reviewed at all levels of the organisation using the Quality Dashboard, with direct links between quality matrices and staffing being made; this is evidenced through Directorate, Care Group and Trust meeting minutes. The Trust utilises a documented internal red flag system that sets 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 are highlighted on the relevant risk register.

Nursing establishment skill mix reviews are 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 is prepared and taken to Board of Directors.

All service changes, including skill mix changes have a Quality Impact Assessment review undertaken.

Information governance

In line with NHS England/Improvements guidance, risks to data security are being 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.

In 2019/20, the Data Security and Protection (DSP) Toolkit was 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 (which, in the past, often led to papers being created only for the purpose of meeting IG Toolkit requirements), and instead sets out the standards that organisations are required to meet with an expectation that this will be an ongoing journey towards compliance.

The Trust's Information Governance Assessment Report for 2019/20 has been impacted by the Covid-19 pandemic. As a result the Trust was unable to reach the target for 95% of staff to be compliant with IG training at the end of March. The Trust has therefore voluntarily submitted an improvement plan to NHS Digital detailing how it intends to meet this target later in the year.

Therefore the overall score for 2019/20 was 99% on mandatory requirements, and was graded as "Standards not fully met (Plan Agreed)".

During 2019/20, no Level 2 Information Governance breaches were reported.

Other regulation

The Trust is fully compliant with the registration requirements of the Care Quality Commission. In the report published in June 2018, the Trust received an overall rating of ‘Good’ and ‘Outstanding’ for its leadership and use of resources. The Trust has not been reassessed in 2019/2020.

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

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

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

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

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

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

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

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

The Trust monitoring mechanism for finance using the Use of Resources rating within the Single Oversight Framework (with a range from 1 (low risk) to 4 (high risk)) recorded a rating of 2 for the financial year ending 31 March 2020. In the financial year ending 31 March 2020 the Trust was part of the Dorset ICS which accepted a system control total approach. Each NHS organisation within the Dorset ICS achieved its individual control total, supporting the achievement of the aggregate system control total. As a result, all available national sustainability funding was secured.

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. However in keeping with previous years an annual Quality Report has been produced and presented to the Board of Directors for approval.

The production of the Annual Quality Report has been overseen by the Director of Nursing and Midwifery and co-ordinated by the Associate Director of Quality and Risk. This team leads on all regulatory quality assessments for the Trust and is experienced in this type of work. To ensure a balanced approach and data accuracy, input to the report was obtained from a wide range of sources within the organisation through the Trust governance infrastructure.

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

Review of effectiveness

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

Conclusion

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

Debbie Fleming, Interim Joint Chief Executive, 24 June 2020

Consolidated financial statements

For the year ended
31 March 2020

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The Foundation Trust

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

Foreword to the accounts

These accounts for the year ended 31 March 2020 for The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (the "Foundation Trust") have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Mrs D Fleming
Interim Chief Executive
24 June 2020

Accounting Officer's Statement

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Royal Bournemouth and Christchurch Hospitals NHS foundation trust to prepare for each financial 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 The Royal Bournemouth and Christchurch Hospitals NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial 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
Interim Chief Executive
24 June 2020

KPMG

Independent auditor's report

to the Council of Governors of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

. **REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS**

1. Our opinion is unmodified

We have audited the financial statements of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2020 which comprise the Group and Trust Statement of Comprehensive Income, Group and Trust Statement of Financial Position, Group and Trust Statement of Changes in Equity and Group and Trust Statement 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 2020 and of its income and expenditure for the year then ended; and

— the Group and Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2019/20 and the Department of Health and Social Care (DHSC) Group Accounting Manual 2019/20.

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.

Overview		
Materiality: Group financial statements as a whole	£6.4 million (2019: £6.3 million) 1.9% of total operating income (2019: 1.9%)	
Risks of material misstatement		**vs 2019**
Recurring risks	Valuation of land and buildings	▲
	Recognition of NHS and non-NHS Income	◄►
	Recognition of Non-Pay Expenditure	◄►

Key

◄► Risk level unchanged from prior year

▲ Increased risk in the year

Emphasis of matter- going concern basis of preparation

We draw your attention to note 1.20 to the financial statements, which discloses that the Boards of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust have announced their intention to merge the operations, assets and liabilities of both trusts into a single new trust.

Whilst the Trust is not a going concern due to its planned dissolution during the next 12 months, the financial statements of the Trust have been prepared on a going concern basis because its services will continue to be provided by the successor trust. Our opinion is not modified in respect of this matter.

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

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

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Land and Buildings (£155.2 million; 2019: £163.2 million) *Refer to page 40 of the Annual Report (Audit Committee Report), note 1.5 of the consolidated financial statements (accounting policies) and note 14 & 30 of the consolidated financial statement (financial disclosures)*	**Subjective valuation** Land and buildings are required to be held at current value in existing use. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'. 98% of the group's assets are deemed to be specialised assets as at 31 March 2020. When considering the cost to build a replacement asset the Group may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. The valuation is completed by an external expert engaged by the Trust using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with interim desktop valuations completed in interim periods. The Trust had a full valuation undertaken by an external valuer at 31 March 2020. The report of the valuer contains the standard RICS disclosure of a material valuation uncertainty due to the outbreak of COVID-19. Valuations are inherently judgemental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, were appropriate and correctly applied. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole. **Disclosure of Sensitivity** Appropriate disclosure will be required of the impact of COVID-19 on market-based valuations of land and buildings and the sensitivity of the valuation to changes in estimates and judgements made by the valuer. Note 30 within the financial statements discloses this valuation uncertainty.	Our procedures included: — **Assessing valuer's credentials:** We considered the scope, qualifications and experience of the valuer, to identify whether the valuer was appropriately experienced and qualified to provide relevant indices; — **Methodology choice:** We considered the overall methodology of the external valuation performed to identify whether the approach was in line with industry practice, assisted by our Estate Valuation specialist; — **Benchmarking assumptions**: We critically assessed the assumptions used within the valuation by assessing the assumptions used to derive the carrying value of assets against BCIS all in tender price index and industry norms and utilising our Estate Valuation specialist; — **Tests of detail:** We undertook the following tests of detail: — We tested the completeness of the estate covered by the valuation to the Trust's underlying estate records, including additions to land and buildings during the year; — We re-performed the calculation of gain or loss on revaluation for all applicable assets and checked whether the accounting entries were consistent with the DHSC Group Accounting Manual; and — For a sample of assets added during the year we agreed that an appropriate valuation basis had been adopted when they became operational and that the Trust would receive future benefits. — **Assessing transparency:** We assessed the completeness and accuracy of the matters covered in the valuation disclosure, including the group's disclosures of the sensitivity of the valuation to changes in key assumptions. — **Our results:** From the evidence obtained, we found the resulting valuation of land and buildings and related disclosures to be acceptable.

2. Key audit matters: our assessment of risks of material misstatement (cont.)

	The risk	Our response
Recognition of NHS and non-NHS income (£334.8 million; 2019: £337.5 million) *Refer to page 40 of the Annual Report (Audit Committee Report), note 1 of the financial statements (accounting policies) and note 4 of the financial statement (financial disclosures)*	**Effects of Irregularities** Of the Groups reported total income, £286 million (2019: £262.3 million) came from commissioners (Clinical Commissioning Trusts (CCG), other NHS Bodies and NHS England). Income from CCGs, other NHS Bodies and NHS England make up 85% of the Trust's income. The majority of this income is contracted on an annual basis, however actual income is based on completing actual levels of activity completed during the year. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are produced setting out discrepancies between the submitted balances and transactions between each party, with variances over £300,000 being required to be reported to the National Audit Office to inform the audit of the DHSC consolidated accounts. The Group reported total other income of £37.5 million (2019: £64.1 million) from other activities principally, education and training and non-patient care activities. Much of this income is generated by contracts with other NHS and non-NHS bodies which are based on achieving financial targets, varied payment terms, including payment on delivery, milestone payments and periodic payments. The amount also includes £7.3 million (2019: £30.6 million) Provider Sustainability Funding (PSF) received from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. As such there is a fraudulent risk of revenue recognition over both NHS and Non-NHS income.	Our procedures included: **Control observations:** We tested the design and operation of process level controls over revenue recognition; **Test of details:** We undertook the following tests of details: — We agreed commissioner income to the signed contracts and selected a sample of the largest balances (comprising 90% of income from [patient care activities]) to the supporting invoice and payments to the bank receipts; — We inspected invoices for material income in the month prior to and following 31 March 2020 to determine whether income was recognised in the correct accounting period, in accordance with the amounts billed to corresponding parties; — We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant income recorded in the Group's financial statements to the expenditure balances recorded within the accounts of Commissioners. Where applicable, we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Group's approach to recognising income; — We assessed the judgements made to received the transformation funding recorded in the financial statements as part of the Trust's performance against the required targets to confirm eligibility for the income and agreed bonus amounts to correspondence from NHSI; and — We tested material other income balances by agreeing a sample of income transactions through to supporting documentation and/or cash receipts. **Our results:** — The results of our testing were satisfactory and we found the recognition of NHS and non-NHS income to be acceptable.

2. Key audit matters: our assessment of risks of material misstatement (cont.)

	The risk	Our response
Recognition of non-pay expenditure (£118 million; 2019: £114 million) *Refer to page 40 of the Annual Report (Audit Committee Report), note 1 of the financial statements (accounting policies) and note 7 of the financial statement (financial disclosures)*	**Effects of Irregularities:** As most public bodies are net spending bodies the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this risk when planning and performing our audit procedures. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of recognition of non-pay expenditure at the year-end. There may therefore be an incentive to defer non-pay expenditure or recognise commitments at a reduced value in order to achieve financial targets.	Our procedures included: **Control observations:** We tested the design and operation of process level controls over expenditure approval; **Tests of detail:** We undertook the following tests of detail: — We agreed a specific item sample of non pay expenditure transactions to supporting evidence and cash; — We tested invoices for material expenditure in the month prior to and following 31 March 2020 to determine whether expenditure had been recognised in the correct accounting period relevant to when services were delivered; — We assessed the completeness and judgements made within the expenditure balance, specifically accrued expenditure, through comparison to historical performance; and — We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant payables recorded in the Trust's financial statements to the receivables balances recorded within the accounts of other providers and other bodies within the AoB boundary. Where applicable, we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure with other providers and other bodies within the AoB boundary. **Our results:** — The results of our testing were satisfactory and we found the recognition of non-pay expenditure to be acceptable.

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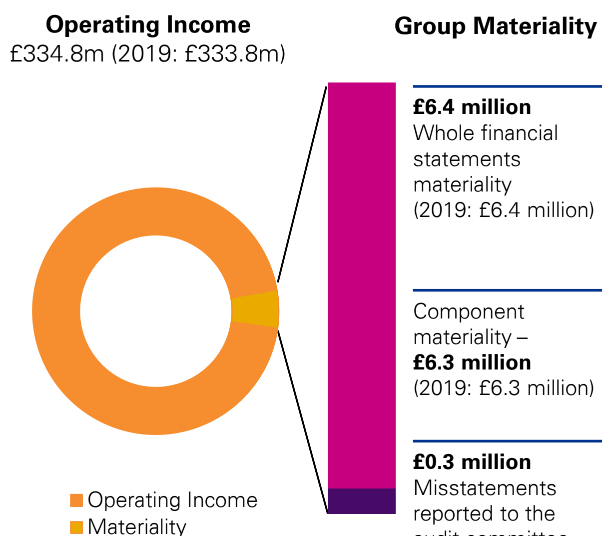
3. Our application of materiality and an overview of the scope of our audit

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

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

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3m (2019: £0.3m), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Of the group's three reporting components, we subjected one component to a full scope audit for group reporting purposes. The remaining components were not individually financially significant enough to require a full scope audit for group reporting purposes, but did present specific individual risks that needed to be addressed. The component within the scope of our work accounted for the percentages illustrated below:



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

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

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

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/19.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

5. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 5, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its 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

We have nothing to report on the statutory reporting matters

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

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is unqualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the 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 Schedule 10 paragraph 1(d), 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, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017**,** as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

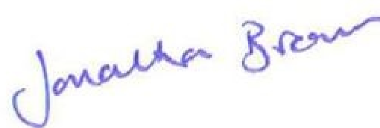
No significant risks were identified during our risk assessment.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust for the year ended 31 March 2020 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.



Jonathan Brown

for and on behalf of KPMG LLP

Chartered Accountants

66 Queen Square,

Bristol, BS1 4BE

24 June 2020

KPMG

Statement of Comprehensive Income

		Group		Trust	
	Notes	**2019/20**	2018/19	**2019/20**	2018/19
		£'000	£'000	**£'000**	£'000
Operating income from continuing operations	4	**334,847**	337,495	**333,881**	336,381
Operating expenses of continuing operations	7	**(335,906)**	(309,834)	**(335,046)**	(307,949)
OPERATING (DEFICIT) / SURPLUS		**(1,059)**	27,661	**(1,165)**	28,432
FINANCE COSTS					
Finance income: interest receivable	12	**404**	244	**398**	241
Finance expense: interest payable	13	**(480)**	(512)	**(480)**	(512)
Finance expense: Unwinding of discount on provisions	23	**1**	1	**1**	1
Public Dividend Capital: Dividends payable		**(4,641)**	(4,785)	**(4,641)**	(4,785)
Gain on disposal of assets		**-**	87	**-**	87
Gain on sale of interest in Joint Venture		**-**	3,385	**-**	3,385
Movement in fair value of investment property and other investments		**(214)**	139	**-**	-
Profit from Joint Venture		**3,767**	1.012	**3,767**	1,012
(DEFICIT) / SURPLUS FOR THE YEAR		**(2,222)**	27,234	**(2,120)**	27,861
Other comprehensive income					
Impairment (chargeable to revaluation reserve)		**(6,207)**	(1,837)	**(6,207)**	(1,837)
Revaluation (credited to revaluation reserve)		**1,727**	-	**1,727**	-
TOTAL COMPREHENSIVE (EXPENSE) / INCOME FOR THE YEAR		**(6,702)**	25,397	**(6,600)**	26,024

The notes on pages 18 to 57 form part of these accounts.

Statement of Financial Position

		Group		Trust	
	Notes	**31 March 2020**	31 March 2019	**31 March 2020**	31 March 2019
		£'000	£'000	**£'000**	£'000
Non-current assets					
Intangible assets	14	**12,260**	5,851	**12,260**	5,851
Property, plant and equipment	14	**180,663**	184,476	**180,657**	184,301
Investments in LLP Joint Venture	12.1	**1,907**	1,075	**1,907**	1,075
Other Investments	12.2	**3,990**	4,204	**-**	-
Trade and other receivables	18	**746**	-	**746**	-
Total non-current assets		**199,566**	195,606	**195,570**	191,227
Current assets					
Inventories	17	**4,816**	5,074	**4,816**	5,074
Trade and other receivables	18	**19,115**	46,152	**19,065**	45,521
Other financial assets		**47**	66	**-**	-
Cash and cash equivalents	19	**60,538**	38,554	**57,753**	35,456
Total current assets		**84,516**	89,846	**81,634**	86,051
Current liabilities					
Trade and other payables	20	**(47,235)**	(46,056)	**(45,312)**	(42,939)
Borrowings	21	**(1,370)**	(1,249)	**(1,370)**	(1,249)
Provisions	23	**(385)**	(1,093)	**(385)**	(1,093)
Total current liabilities		**(48,990)**	(48,398)	**(47,067)**	(45,281)
Total assets less current liabilities		**235,092**	237,054	**230,137**	231,997
Non-current liabilities					
Trade and other payables	20	**(885)**	(918)	**(885)**	(918)
Borrowings	21	**(14,540)**	(15,543)	**(14,540)**	(15,543)
Provisions	23	**(2,042)**	(759)	**(2,042)**	(759)
Total non-current liabilities		**(17,467)**	(17,220)	**(17,467)**	(17,220)
Total assets employed:		**217,625**	219,834	**212,670**	214,777
Taxpayers' equity					
Public Dividend Capital		**85,184**	80,691	**85,184**	80,691
Revaluation reserve		**67,895**	73,266	**67,895**	73,266
BHT Charitable Fund Reserve		**1,541**	1,700	**-**	-
Income and expenditure reserve		**59,591**	60,820	**59,591**	60,820
NHS Charitable Fund Reserve	33	**3,414**	3,357	**-**	-
Total Taxpayers' equity:		**217,625**	219,834	**212,670**	214,777

The notes on pages 18 to 57 form part of these accounts.

The financial statements comprising the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, and Statement of Cash Flows were approved by the Foundation Trust Board on 24 June 2020 and signed on its behalf by:

Mrs D Fleming, Interim Joint Chief Executive 24 June 2020

Statement of Changes in Taxpayers' Equity

	Trust				BHT Charity	RBCH Charity	Group
	Public Dividend Capital	**Revaluation Reserve**	**Income and Expenditure Reserve**	**Trust Reserves**	**Other Reserves**	**Charitable Fund Reserve**	**Total Reserves**
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Current Year							
Taxpayers' Equity at 1 April 2019	**80,691**	**73,266**	**60,820**	**214,777**	**1,700**	**3,357**	**219,834**
Surplus/(deficit) for the year	-	-	(2,120)	(2,120)	(160)	57	**(2,222)**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	-	(891)	891	-	-	-	**-**
Revaluations of property, plant and equipment	-	(6,207)	-	(6,207)	-	-	**(6,207)**
Impairment losses on property, plant and equipment	-	1,727	-	1,727	-	-	**1,727**
Public Dividend Capital received	4,493	-	-	4,493	-	-	**4,493**
Taxpayers' Equity at 31 March 2020	**85,184**	**67,895**	**59,591**	**212,670**	**1,541**	**3,414**	**217,625**
Prior Year							
Taxpayers' Equity at 1 April 2018	**80,679**	**75,103**	**32,959**	**188,741**	**2,018**	**3,666**	**194,425**
Surplus/(deficit) for the year	-	-	27,861	27,861	(318)	(309)	**27,234**
Impairment losses on property, plant and equipment	-	(1,837)	-	(1,837)	-	-	**(1,837)**
Public Dividend Capital received	12	-	-	12	-	-	**12**
Taxpayers' Equity at 31 March 2019	**80,691**	**73,266**	**60,820**	**214,777**	**1,700**	**3,357**	**219,834**

The notes on pages 18 to 57 form part of these accounts.

Statement of Cash Flows

	Notes	Group				Trust			
		2019/20		2018/19		2019/20		2018/19	
		£'000		£'000		£'000		£'000	
Cash flows from operating activities									
Operating surplus/(Deficit)			(1,059)		27,661		(1,166)		28,432
Non-cash income and expense									
Depreciation and amortisation	14	8,983		6,714		8,810		6,541	
Impairments / Reversal of Impairments	14	3,193		987		3,193		987	
Non-cash donations/grants credited to income		-		(750)		(1,167)		(750)	
(Increase)/Decrease in Trade and Other Receivables		26,193		(18,357)		26,395		(18,099)	
(Increase)/Decrease in Inventories		258		(475)		258		(475)	
Increase/(Decrease) in Trade and Other Payables		664		5,741		771		5,421	
Increase/(Decrease) in Other Liabilities		1,917		707		1,917		707	
(Increase)/Decrease in provisions		576		958		576		958	
NHS Charitable Fund - net adjustments for working capital movements and non-cash transactions		(1,816)		856		-		-	
Other movements in operating cash flows		2,925		435		2,560		496	
(Increase)/Decrease in provisions			42,893		(3,184)		43,313		(4,214)
Net cash flow from operations			41,834		24,477		42,147		24,218
Cash flow from investing activities									
Interest received		384		229		384		229	
Purchase of intangible assets		(6,904)		(1,295)		(6,904)		(1,295)	
Purchase of property, plant and equipment		(11,394)		(10,953)		(11,394)		(10,953)	
Sales of Property, Plant and Equipment		-		87		-		87	
Net cash flow from investing activities			(17,914)		(11,932)		(17,914)		(11,932)
Cash flow from financing activities									
Public dividend capital received		4,493		12		4,493		12	
Loans received and received		(1,102)		(1,102)		(1,102)		(1,102)	
Capital element of finance lease rental payments		(292)		(166)		(292)		(166)	
Interest paid on ITFF loan		(472)		(501)		(472)		(501)	
Interest element of finance leases	13	(8)		(11)		(8)		(11)	
PDC dividend paid		(4,555)		(4,363)		(4,555)		(4,363)	
			(1,936)		(6,131)		(1,936)		(6,131)
Net increase in cash and cash equivalents			21,984		6,414		22,297		6,155
Cash and cash equivalents at beginning of year			38,554		32,140		35,456		29,301
Cash and cash equivalents at end of year	19		60,538		38,554		57,753		35,456

The notes on pages 18 to 57 form part of these accounts.

Notes to the accounts

1 Accounting policies

1.1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Acquisitions and discontinued operations

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

Critical accounting judgements and key sources of estimation uncertainty

In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually revised.

Details of key accounting judgements and estimations are contained within Note 30 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 2019/20. These Standards are still subject to HM Treasury FreM adoption, with IFRS 16 government implementation date 1st April 2021, and the government implementation date for IFRS 17 on or after 1st January 2023.

- IFRS 16 Leases: Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. Further information is provided in Note 1.21

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

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

Prior year restatements

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

Basis of consolidation

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

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund

The NHS Foundation Trust is the corporate trustee of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund (Charity Registration number 1057366). The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

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

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

The Bournemouth Healthcare Trust - Company Registration Number: 06430101

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

As a result of this, the NHS Foundation Trust has reassessed its relationship to BHT (including its trading subsidiary BPC), and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charity and has the ability to affect those returns and other benefits through its power over the charity.

The charity’s statutory accounts are prepared to 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.

This resulted in a net income and expenditure deficit of £160,000 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.

Dorset Heart Clinic Limited Liability Partnership: Company Registration Number OC414702

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

1.2 Revenue

Revenue from contracts with customers

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

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the 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 performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time, depending upon the terms of the contract.

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

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Full actuarial (funding) valuation

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

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

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

National Employment Savings Trust (NEST)

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

1.4 Expenditure on other goods and services

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

1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust;
- it is expected to be used for more than one financial 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 full valuation (excluding Assets Under Construction/ Work In Progress) was undertaken as at 31 March 2020, and this value has been included in the closing Statement of Financial Position.

The valuations are carried out primarily on the basis of Modern Equivalent for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

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

Operational equipment is valued at net current replacement cost.

Subsequent expenditure

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

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

Depreciation

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

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

As at 31 March 2020, there were no assets classified as 'Held for Sale'.

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.

	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

De-recognition

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

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

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

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

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/ grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/ grant is deferred within liabilities and is carried forward to future financial 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 23 but is not recognised in the Trust's accounts.

Non-Clinical Risk Pooling

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

1.12 Contingencies

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

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

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

1.13 Public Dividend Capital (PDC) and PDC Dividend

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

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

A charge, reflecting the cost of capital utilised by the Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant

net assets of the Foundation Trust during the financial 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) 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 (iii) any PDC dividend balance receivable or payable.

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

In the preparation of the year end accounts the Board of Directors is required to undertake an assessment confirming the Trust will continue as a going concern (i.e. that it will continue in the business of healthcare provision for the foreseeable future).

The Trust has prepared its financial plans and cash flow forecasts for the coming year on the assumption that funding will be received from the Department of Health and Social Care consistent with the revised funding arrangements in response to the COVID-19 pandemic. Discussions to date indicate this funding will be forthcoming. These funds are expected to be sufficient to enable the Trust to meet its obligations as they fall due; and

will be accessed through the nationally agreed process published by NHS Improvement and the Department of Health and Social Care.

The NHS Improvement Foundation Trust Annual Reporting Manual 2019/20 states that financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

There has been no application to the Secretary of State for the dissolution of the Trust and following the preparation of detailed financial plans for 2020/21, no such application is planned.

The boards of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust announced their intention to merge the operations, assets and liabilities of both into a single new trust. The proposed merger is currently subject to due diligence and regulatory review. Although the merger process has been delayed as a result of the COVID-19 pandemic, both boards anticipate the merger will be completed within the next 12 months. Formal board approval for the merger will be subject to confirmation by independent Reporting Accountants that the merged trust will have sufficient working capital and satisfactory governance arrangements to continue post-merger as a going concern.

The Board of Directors has therefore concluded that there is a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the next 12 months.

1.21 Investments

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

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

Charitable Fund Fixed Asset Investments

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

The Trustee's policy is to invest charitable funds with investments that maximise capital and are the most suitable investment type. The long-term objective is to invest capital that will give the maximum growth on income with minimal risk. The investment held as at the Statement of Financial Position date are units within a Restricted Investment Portfolio and are included in the Statement of Financial Position at the closing price at 31 March 2020. Investments comprise equities, gilts, other fixed interest investments and pooled funds, the majority of which are quoted investments.

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

Charitable Fund Short-Term Investments

Short-Term Investments include Stocks and Equities that have been received as part of Legacy distributions given to the Charitable Fund. These are revalued at the 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 2021. 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 re-measurement 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 2021, 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 2021 for existing finance leases.

For leases commencing in 2021/22, 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 year ended 31 March 2020 is as follows:

	Group		Trust	
	Healthcare 2019/20	Healthcare 2018/19	**Healthcare 2019/20**	Healthcare 2018/19
	£'000	£'000	**£'000**	£'000
Segment revenue	**334,847**	337,495	**333,881**	336,381
Patient and other income	**334,847**	337,495	**333,881**	336,381

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

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

3 Income generation activities

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

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

4 Operating income

4.1 Income from patient related activities

	Group		Trust	
	Continuing Operations 2019/20	Restated Continuing Operations 2018/19	**Continuing Operations 2019/20**	Restated Continuing Operations 2018/19
	£'000	£'000	**£'000**	£'000
Foundation Trusts	**6,849**	4,276	**6,849**	4,276
Clinical Commissioning Groups	**227,600**	215,837	**227,600**	215,837
NHS England	**58,434**	46,417	**58,434**	46,417
Local authorities	**252**	410	**252**	410
Department of Health and Social Care	**227**	2,891	**227**	2,891
NHS Other	**93**	88	**93**	88
Non NHS:				
- Private Patients	**3,325**	2,913	**2,445**	2,399
- Overseas Patients (non-reciprocal)	**184**	154	**184**	154
- NHS Injury Scheme Income	**351**	362	**351**	362
	297,315	273,348	**296,435**	272,834

The Trust recognises an notional income amount of £8,681,000 for the additional pension contribution that is funded centrally. This is included within the NHS England figures above and is matched by notional expenditure as detailed in Note 7.

The NHS Injury Scheme Income above is reported gross and a 21.79% doubtful debt provision (2018/19: 21.89%) is included in expenditure, which represents expected recovery rates.

4.2 Other operating income

	Group		Trust	
	Continuing Operations 2019/20	Restated Continuing Operations 2018/19	**Continuing Operations 2019/20**	Restated Continuing Operations 2018/19
	£'000	£'000	**£'000**	£'000
Research and development	**2,479**	2,585	**2,479**	2,585
Education and training	**9,487**	8,062	**9,487**	8,062
NHS Charities - capital acquisitions (donated assets)	**-**	750	**926**	750
NHS Charities - contributions to expenditure	**-**	-	**241**	-
Received from other bodies: Other charitable and other contributions to expenditure	**1,634**	6,676	**1,634**	6,676
Non-patient care services to other bodies	**4,934**	5,514	**4,934**	6,669
National Sustainability Funding	**7,306**	30,555	**7,306**	30,555
NHS Charitable Funds: Incoming Resources excluding investment income	**1,381**	1,757	**-**	-
Other:				
- NHS drug sales	**31**	139	**31**	139
- car parking	**2,030**	1,939	**2,030**	1,939
- catering services	**1,292**	1,045	**1,292**	1,045
- miscellaneous other	**5,773**	3,774	**5,901**	3,776
Income from operating leases	**1,185**	1,351	**1,185**	1,351
	37,532	64,147	**37,446**	63,547
Total	**334,847**	337,495	**333,881**	336,381

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	
	2019/20	2018/19	**2019/20**	2018/19
	£'000	£'000	**£'000**	£'000
Commissioner requested services	**306,802**	281,410	**305,922**	280,896
Non Commissioner requested services	**28,045**	56,085	**27,959**	55,485
	334,847	337,495	**333,881**	336,381

7 Operating expenses

	Group		Trust	
	Continuing Operations		Continuing Operations	
	2019/20	2018/19	**2019/20**	2018/19
	£'000	£'000	**£'000**	£'000
Purchase of healthcare from NHS and Department of Health and Social Care (DHSC) bodies	**4,308**	4,130	**4,308**	4,130
Purchase of healthcare from non-NHS and non-DHSC bodies	**2,928**	2,068	**2,928**	2,068
Purchase of social care	**153**	160	**153**	160
Employee Expenses - Executive directors	**1,043**	1,260	**1,043**	1,260
Employee Expenses - Non-executive directors	**127**	150	**127**	150
Employee Expenses - Staff	**205,760**	191,673	**205,760**	191,597
Employee Expenses - Redundancy	**-**	438	**-**	438
Employee Expenses - Research and development	**2,280**	2,297	**2,280**	2,297
Employee Expenses - Notional employer contributions paid by NHSE (6.3%)	**8,681**	-	**8,681**	-
Supplies and services - clinical (excluding drug costs)	**32,004**	32,040	**32,004**	32,040
Supplies and services - general	**4,336**	4,025	**4,336**	4,025
Establishment	**2,634**	1,993	**2,634**	1,993
Research and development (excluding Employee Expenses)	**232**	259	**232**	259
Transport (staff travel)	**559**	531	**559**	531
Transport (patient transport services)	**500**	392	**500**	392
Premises - Rates	**1,727**	1,286	**1,727**	1,286
Premises	**10,245**	10,347	**10,245**	10,347
Movement in credit loss allowance: all other receivables and investments	**(19)**	730	**(19)**	730

	Group		Trust	
	Continuing Operations		Continuing Operations	
	2019/20	2018/19	**2019/20**	2018/19
	£'000	£'000	**£'000**	£'000
Provisions arising / released in year	**(660)**	1,096	**(660)**	1,096
Change in provisions discount rate(s)	**(77)**	-	**(77)**	-
Inventories written down	**2**	78	**2**	78
Drug costs	**33,894**	33,137	**33,894**	33,137
Operating lease payments	**-**	137	**-**	137
Depreciation on property, plant and equipment	**8,325**	6,120	**8,152**	5,947
Amortisation on intangible assets	**658**	594	**658**	594
Impairments net of reversals	**3,193**	987	**3,193**	987
Audit fees:				
External audit services - financial statement audit	**68**	52	**68**	52
External audit services - audit-related assurance services	**4**	8	**4**	8
External audit services - charitable fund accounts	**5**	4	**-**	-
Internal Audit and Counter Fraud	**100**	102	**100**	102
Clinical negligence premium	**3,939**	4,282	**3,939**	4,282
Legal fees	**42**	818	**42**	818
Consultancy costs	**1,098**	261	**1,098**	261
Training, courses and conferences	**1,827**	1,841	**1,827**	1,841
Insurance	**335**	341	**335**	341
Other services, e.g. external payroll	**625**	572	**625**	572
Losses, ex gratia and special payments	**16**	18	**16**	18
NHS charitable funds: Other resources expended (balance not analysed above)	**91**	1,051	**-**	-
Other	**4,843**	4,474	**4,252**	3,893
Total	**335,906**	309,834	**335,046**	307,949

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

8 Operating leases

8.1 Operating leases as lessee

The Foundation Trust leases some medical equipment and vehicles under non-cancellable operating leases. The leases are between 3-5 years. None of the leases include contingent rents or onerous restrictions on the Foundation Trust's use of the assets concerned. The expenditure charged to the Statement of Comprehensive Income during the year is disclosed below:

	Group / Trust	
	2019/20	2018/19
	£'000	£'000
Total operating leases	**-**	137
The future aggregate minimum lease payments under non-cancellable operating leases are as follows:		
Lease ending:		
No later than one year	**-**	137
Total	**-**	137

8.2 Operating leases as lessor

The Foundation Trust leases some medical equipment and vehicles under non-cancellable operating leases. The leases are between 3-5 years. None of the leases include contingent rents or onerous restrictions on the Foundation Trust's use of the assets concerned. The expenditure charged to the Statement of Comprehensive Income during the year is disclosed below:

	Group / Trust	
	2019/20	2018/19
	£'000	£'000
Operating leases	**1,185**	1,351
The future aggregate minimum lease payments under non-cancellable operating leases are as follows:		
No later than one year	**1,074**	1,267
Between one and five years	**649**	741
Over five years	**2,668**	2,784
Total	**4,391**	4,792

9 Staff costs and numbers

9.1 Staff costs

	Group		Trust	
	2019/20	2018/19	**2019/20**	2018/19
	£'000	£'000	**£'000**	£'000
Salaries and wages	**170,573**	158,842	**170,573**	158,766
Social security costs	**15,890**	14,857	**15,890**	14,857
Employer's contributions to NHS Pensions	**19,887**	18,651	**19,887**	18,651
Apprenticeship Levy	**826**	771	**826**	771
Pension Cost - other contributions	**8,740**	27	**8,740**	27
Agency/contract staff	**4,536**	4,580	**4,536**	4,580
Capitalised Agency/contract staff	**294**	-	**294**	-
Total	**220,746**	197,728	**220,746**	197,652

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

9.2 Average number of employees

	Group	
	2019/20	2018/19
	£'000	£'000
Medical and dental	**507**	503
Administration and estates	**854**	839
Healthcare assistants and other support staff	**1,391**	1,328
Nursing, midwifery and health visiting staff	**1,223**	1,193
Scientific, therapeutic and technical staff	**408**	399
Healthcare science staff	**81**	89
Total	**4,464**	4,351
Of which:		
Permanent	**4,086**	3,994
Other	**378**	357
Total	**4,464**	4,351

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

9.3 Staff exit packages

	Group		Trust	
	2019/20	**2019/20**	2018/19	2018/19
	Number	**£'000**	Number	£'000
Less than £10,000	-	-	3	24
£10,001 - £25,000	-	-	2	43
£25,001 - £50,000	-	-	5	211
Over £ 200,000	-	-	1	275
Total	-	-	11	553

There were no exit packages in 2019/20. In 2018/19 the above exit packages were in relation to 1 compulsory redundancy and 10 agreed departures.

The 2018/19 compulsory redundancy relates to the Chief Executive, following the agreement of a joint interim management structure with Poole Hospital NHS Foundation Trust. Under this arrangement the two Trusts now have a single Interim Joint Chair and Chief Executive, with effect from 1 January 2019. The value included above represents the full contractual exit package, however a contribution of 50% was received from Poole Hospital NHS Foundation Trust.

10 Retirements due to ill-health

There were four early retirements from the Foundation Trust agreed on the grounds of ill-health (2018/19: four). The estimated additional pension liabilities of these ill-health retirements will be £386,000 (2018/19: £221,000). Any costs of ill-health retirements are borne by the NHS Pensions Agency.

11 Late Payment of Commercial Debts (Interest) Act 1998

There were minimal payments of interest for commercial debts.

12 Investment revenue

	Group		Trust	
	2019/20	2018/19	**2019/20**	2018/19
	£'000	£'000	**£'000**	£'000
Interest on bank accounts	**398**	241	**398**	241
NHS charitable funds: investment income	**6**	4	**-**	-
Total	**404**	245	**398**	241

12.1 Investment in joint venture

	Group / Trust	
	2019/20	2018/19
	£'000	£'000
Opening Balance	**1,075**	6,857
Share of profit / (loss)	**3,768**	1,012
Disbursements / dividends received	**(2,909)**	(441)
Sale of stake	**(27)**	(6.353)
Closing Balance	**1,907**	1,075

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

12.2 Charity investments

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£'000	£'000	**£'000**	£'000
Opening Balance	**4,204**	4,065	**-**	-
Movement in fair value	**(214)**	139	**-**	-
Closing balance	**3,990**	4,204	**-**	-

12.3 Other financial assets

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£'000	£'000	**£'000**	£'000
Fixed Deposit (less than one year)	**47**	66	**-**	-
Total	**47**	66	**-**	-

13 Finance costs

	Group / Trust	
	2019/20	2018/19
	£'000	£'000
Loans from the Independent Trust Financing Facility	**472**	501
Finance leases	**8**	11
Total	**480**	512

14 Intangible assets, property, plant and equipment

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

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

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

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

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

	Group											Trust
	Restated Intangible	Restated Tangible								Restated TOTAL		Restated TOTAL
	Software Licences (incl Work in progess)	Land (Freehold)	Buildings excluding dwellings (Freehold)	Dwellings (Freehold)	Assets Under Construction / Work In Progress	Plant and Machinery	Transport Equipment	Information Technology	Furniture and fittings	Non Current Assets	Less Non-Trust Assets	Trust Assets
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
Gross cost at 1 April 2018	10,870	-	137,799	7,760	-	44,086	376	9,719	958	243,162	1,212	241,950
Adjustment to prior year *	(39)	5,851	(10,745)	(344)	7,368	444	-	-	-	(10,684)	-	(10,684)
Restated Gross cost at 1 April 2018	10,831	5,851	127,054	7,416	7,368	44,530	376	9,719	958	232,478	1,212	231,266
Additions	1,714	-	674	-	3,696	3,043	-	1,377	7	10,511	-	10,511
Additions - donations of physical assets (non-cash)	28	-	-	-	-	690	-	32	-	750	-	750
Impairments - Operating expenses	-	(1,100)	-	(48)	-	-	-	-	-	(1,148)	-	(1,148)
Impairments - Revaluation reserve	-	(1,800)	(37)	-	-	-	-	-	-	(1,837)	-	(1,837)
Reversal of impairments credited to operating expenses	-	-	161	-	-	-	-	-	-	161	-	161
Disposals	-	-	-	-	-	(1,758)	-	-	-	(1,758)	-	(1,758)
Cost or valuation at 31 March 2019	**12,573**	**28,187**	**127,852**	**7,368**	**4,203**	**46,505**	**376**	**11,128**	**965**	**239,157**	**1,212**	**237,945**
Accumulated depreciation at 1 April 2018 as previously stated	6,167	-	8,333	237	-	33,876	184	5,147	614	54,558	864	53,694
Adjustment to prior year *	(39)	-	(10,745)	(344)	-	444	-	-	-	(10,684)	-	(10,684)
Restated Accumulated depreciation at 1 April 2018	6,128	-	(2,412)	(107)	-	34,320	184	5,147	614	43,874	864	43,010
Provided during the year	594	-	2,538	107	-	2,239	34	1,151	51	6,714	173	6,541
Disposals	-	-	-	-	-	(1,758)	-	-	-	(1,758)	-	(1,758)
Accumulated depreciation at 31 March 2019	**6,722**	**-**	**126**	**-**	**-**	**34,801**	**218**	**6,298**	**665**	**48,830**	**1,037**	**47,793**
Net book value												
Owned	4,703	31,087	125,144	7,523	507	7,096	185	4,549	343	181,137	348	180,789
Finance lease	-	-	-	-	-	411	-	-	-	411	-	411
Donated	-	-	4,322	-	-	2,703	7	23	1	7,056	-	7,056
NBV total at 31 March 2019	**4,703**	**31,087**	**129,466**	**7,523**	**507**	**10,210**	**192**	**4,572**	**344**	**188,604**	**348**	**188,256**
Net book value												
Owned	5,851	28,187	122,963	7,523	4,203	8,595	185	4,791	300	182,412	175	182,237
Finance lease	-	-	-	-	-	215	-	-	-	215	-	215
Donated	-	-	4,763	-	-	2,894	7	39	-	7,700	-	7,700
NBV total at 31 March 2019	**5,851**	**28,187**	**127,726**	**7,523**	**4,203**	**11,704**	**192**	**4,830**	**300**	**190,327**	**175**	**190,152**
The asset classifications are as follows:												
- protected	-	24,848	121,189	-	-	-	-	-	-	146,037	-	146,037
- unprotected	5,851	3,339	6,537	7,368	4,203	11,704	158	4,830	300	44,290	175	44,115
Total	**5,851**	**28,187**	**127,726**	**7,368**	**4,203**	**11,704**	**158**	**4,830**	**300**	**190,327**	**175**	**190,152**

*The Foundation Trust has undertaken a reconciliation exercise that has resulted in some movements between opening cost and opening depreciation. There is no impact in the overall value of assets.

Included within Buildings above, there are £745,728 of restricted use assets in relation to the Heart Club which is leased to the Bournemouth Heart Club until the year 2046.

	Restated 2018/19	2017/18
	£'000	£'000
Cost	**746**	3,942
Accumulated depreciation	**-**	3,228
Net book value	**746**	714

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

15 Impairment of property, plant and equipment

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£'000	£'000	**£'000**	£'000
Changes in market price (as advised by the Trust's external valuer)	**3,193**	(113)	**3,193**	(113)
Unforeseen obsolescence	**-**	1,100	**-**	1,100
Total	**3,193**	987	**3,193**	987

16 Capital commitments

	Group	
	31 March 2020	31 March 2019
	£'000	£'000
Property, plant and equipment	**2,627**	634
Intangible assets	**1,888**	1,888
Total	**4,515**	2,522

17 Inventories

	Group / Trust	
	31 March 2020	31 March 2019
	£'000	£'000
Drugs	**1,436**	1,381
Consumables	**3,380**	3,693
Total	**4,816**	5,074

17.1 Inventories recognised in expenses

	Group	
	31 March 2020	31 March 2019
	£'000	£'000
Inventories recognised as an expense in the period	**37,593**	34,566
Write-down of inventories (including losses)	**125**	152
Reversal of write-downs that reduced expenses	**(122)**	(74)
Total	**37,596**	34,644

18 Trade and other receivables

18.1 Amounts falling due within one year:

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£'000	£'000	**£'000**	£'000
Contract receivables (IFRS 15): invoiced	**14,158**	10,429	**14,158**	10,429
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	**4,144**	36,407	**3,499**	35,820
Allowance for impaired contract receivables / assets	**(95)**	(100)	**(95)**	(100)
Allowance for impaired other receivables	**(1,807)**	(2,888)	**(1,807)**	(2,888)
Prepayments (revenue) [non-PFI]	**2,265**	1,539	**2,265**	1,539
Interest receivable	**40**	26	**40**	26
PDC dividend receivable	**222**	308	**222**	308
VAT receivable	**-**	246	**-**	246
Other receivables	**113**	85	**783**	141
NHS charitable funds: receivables	**75**	101	**-**	-
Total	**19,115**	46,152	**19,065**	45,521
Amounts falling due over one year:				
Clinician pension tax provision reimbursement funding from NHSE	**746**	-	**746**	-
Total	**19,861**	46,152	**19,811**	45,521

The provision for impairment of receivables relates to specific receivables.

18.2 Age analysis of trade and other receivables

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£'000	£'000	**£'000**	£'000
Age of impaired receivables:				
0 - 30 days	**1,548**	1,548	**1,548**	1,548
31 - 60 days	**165**	165	**165**	165
61 - 90 days	**49**	49	**49**	49
91 - 180 days	**184**	184	**184**	184
over 180 days	**1,042**	1,042	**1,042**	1,042
Sub-total	**2,988**	2,988	**2,988**	2,988
Age of non-impaired receivables:				
0 - 30 days	**13,902**	39,440	**13,852**	38,809
31 - 60 days	**446**	446	**446**	446
61 - 90 days	**406**	406	**406**	406
91 - 180 days	**1,086**	1,086	**1,086**	1,086
over 180 days	**247**	247	**247**	247
Sub-total	**16,087**	41,625	**16,037**	40,994
Prepayments	**40**	1,539	**40**	1,539
Total	**19,115**	46,152	**19,065**	45,521

18.3 Allowances for credit losses (doubtful debts)

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£'000	£'000	**£'000**	£'000
Contract receivables and contract assets:				
At 1 April	**100**	127	**100**	127
New allowances arising	**113**	82	**113**	82
Utilisation of allowances (where receivable is written off)	**(86)**	(109)	**(86)**	(109)
Reversals of allowances (where receivable is collected in-year)	**(32)**	-	**(32)**	-
At 31 March	**95**	100	**95**	100
All other receivables:				
At 1 April	**2,888**	2,203	**2,888**	2,203
New allowances arising	**975**	1,459	**975**	1,459
Utilisation of allowances (where receivable is written off)	**(1,061)**	(45)	**(1,061)**	(45)
Reversals of allowances (where receivable is collected in-year)	**(995)**	(729)	**(995)**	(729)
At 31 March	**1,807**	2,888	**1,807**	2,888

19 Cash and cash equivalents

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£'000	£'000	**£'000**	£'000
Balance 1 April	**38,554**	32,140	**35,456**	29,302
Net movement in year	**21,984**	6,414	**22,297**	6,154
Balance at 31 March	**60,538**	38,554	**57,753**	35,456
Made up of:				
Cash at commercial banks and in hand	**3,263**	3,508	**478**	410
Cash with the Government Banking Service	**57,275**	35,046	**57,275**	35,046
Cash and cash equivalents	**60,538**	38,554	**57,753**	35,456

The patient monies amount held on trust was £5,970 (2018/19 £2,380) which is not included in the above figures.

20 Trade and other payables

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£'000	£'000	**£'000**	£'000
Amounts falling due within one year:				
Trade payables	**13,532**	17,683	**12,314**	16,487
Capital payables (including capital accruals)	**1,868**	2,088	**1,868**	2,088
Accruals (revenue costs only)	**21,670**	20,143	**21,670**	20,143
Social security costs	**2,971**	-	**2,971**	-
VAT payables	**282**	-	**282**	-
Other taxes payable	**1,328**	1,292	**1,328**	1,292
Deferred Income	**4,879**	2,929	**4,879**	2,929
NHS charitable funds: trade and other payables	**705**	1,921	**-**	-
Total	**47,235**	46,056	**45,312**	42,939
Amounts falling due over one year:				
Amounts due to other related parties	**885**	918	**885**	918
Total	**48,120**	46,974	**46,197**	43,857

This includes outstanding pension contributions at 31 March 2020 of £2,813,000 (2018/19 £2,304,208).

21 Borrowings

	Group / Trust	
	31 March 2020	31 March 2019
	£'000	£'000
Finance lease liabilities		
- Current	**251**	130
- Non current	**199**	100
Total	**450**	230
Independent Trust Financing Facility (ITFF) Loan		
- Current	**1,119**	1,119
- Non current	**14,341**	15,443
Total	**15,460**	16,562

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%.

22 Finance lease obligations

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

	Group / Trust	
	31 March 2020	31 March 2019
	£'000	£'000
Amounts payable under finance leases		
Within one year	**255**	135
Between one and five years	**203**	102
After five years	**-**	-
Less future finance charges	**(8)**	(7)
Total	**450**	230

23 Provisions for liabilities and charges

	Group / Trust				
	£'000	£'000	£'000	£'000	**£'000**
	Early Retirement	Injury Benefit	Other Legal claims	Other	**Total**
At 1 April 2019	188	610	1,054	-	**1,852**
Change in the discount rate	-	(77)	-	-	**(77)**
Arising during the year	39	11	74	1,646	**1,770**
Utilised during the year - accruals	(14)	(4)	(1)	-	**(19)**
Utilised during the year - cash	(5)	-	(60)	-	**(65)**
Reversed unused	-	(62)	(971)	-	**(1,033)**
Unwinding of discount	3	(4)	-	-	**(1)**
At 31 March 2019	211	474	96	1,646	**2,427**
Expected timing of cashflows:					
Within one year	19	15	96	255	**385**
Between one and five years	75	62	-	645	**782**
After five years	117	397	-	746	**1,260**
	211	474	96	1,646	**2,427**

Current and non current

Legal Claims

Liability to Third Party and Property Expense Schemes

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

Other Claims

Clinician Pension Tax Scheme:

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

Late Payment of Commercial Debts (Interest) Act 1998:

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

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

£23,520,000 is included in the provisions of NHS Resolution at 31 March 2020 in respect of clinical negligence liabilities of the Foundation Trust (£19,960,000 at 31 March 2019).

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

During the year 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	197,800	391	-	2,352
NHS West Hampshire CCG	26,285	-	165	-
NHS Wiltshire CCG	1,200	-	16	-
Health Education England	9,263	-	104	-
NHS Resolution (formerly NHS Litigation Authority)	19	4,097	-	-
NHS England - Core	7,750	106	2,315	-
NHS England - South West (South)	45,144	106	1,939	106
NHS Wessex Specialised Commissioning Hub	2,513	-	1,290	-
South West Regional Office	1,863	-	240	-
Dorset County Hospital	771	446	546	87
Dorset Healthcare Unversity NHS FT	5,255	625	282	195
Poole Hospital NHS FT	5,157	5,654	7,120	3,356
University Hospitals Southampton NHS FT	1,159	265	382	180
NHS Blood and Tranplant	15	1,036	-	157
NHS Pension Scheme	-	28,568	-	2,800
Other transactions less than £500,000	30,653	294,612	4,716	38,002
	334,847	335,906	19,115	47,235

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	-	13,141	-	1,132
HM Revenue and Customs	-	23,024	-	1,930
National Insurance Fund	-	12,287	-	1,041
	-	48,452	-	4,103

25 Post statement of financial position events

There are no post Statement of Financial Position events to report within these accounts.

26 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 £404,000 during 2019/20, 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 and as a result of this review, has provided £1,066,000 in relation to doubtful debts. A further £95,000 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 £741,000. 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 £57.75m. As such, the Trust is a minimal risk to its creditors.

27 Financial instruments

27.1 Financial assets

	Group				Trust	
	31 March 2020		31 March 2019		**31 March 2020**	31 March 2019
	£'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	**17,299**	**-**	43,958	-	**17,299**	43,958
Other Investments	**2,265**	**-**	1,539	-	**2,265**	1,539
Cash and cash equivalents at bank and in hand	**59,859**	**-**	37,591	-	**59,859**	37,591
NHS charitable funds: financial assets as at 31 March	**753**	**4,037**	1,064	4,270	**-**	-
Total	**80,176**	**4,037**	84,152	4,270	**79,423**	83,088
Assets held in £ sterling		**84,213**		88,422	**79,423**	83,088

The above amount excludes PDC receivables of £222,000 (2018/19 £308,000).

27.2 Financial liabilities

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£'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	**15,460**	16,562	**15,460**	16,562
Obligations under finance leases	**450**	230	**450**	230
NHS trade and other payables excluding non-financial liabilities	**5,351**	3,927	**5,351**	3,927
Non-NHS trade and other payables excluding non-financial liabilities	**31,719**	35,770	**31,719**	35,770
Provisions under contract	**2,427**	883	**2,427**	883
NHS charitable funds: financial liabilities as at 31 March	**705**	1,921	**-**	-
Total	**56,112**	59,293	**55,407**	57,372
Liabilities held in £ sterling	**56,112**	59,293	**55,407**	57,372

The above figures exclude statutory/non-contracted payables of £7,111,000 (2018/19 £6,802,000).

27.3 Financial assets / liabilities - fair values

	Group		Trust	
	31 March 2020		31 March 2020	
	£'000	£'000	£'000	£'000
	Book Value	Fair Value	Book Value	Fair Value
Financial assets				
Receivables over one year				
NHS charitable funds: non-current financial assets	**3,990**	**3,990**	**-**	**-**
Total	**3,990**	**3,990**	**-**	**-**
Financial liabilities				
Non-current trade and other payables excluding non-financial liabilities	**885**	**885**	**885**	**885**
Provisions under contract	**2,427**	**2,427**	**2,427**	**2,427**
Total	**3,312**	**3,312**	**3,312**	**3,312**

28 Intra-government and NHS balances

	Group / Trust	
	31 March 2020	
	Receivables: amounts falling due within one year	Payables: amounts falling due within one year
	£'000	£'000
Providers	**8,525**	**4,145**
NHS and Department of Health	**6,663**	**2,465**
Local Government	**204**	**-**
Central Government	**35**	**7,541**
Total	**15,427**	**14,151**
	31 March 2019	
Providers	3,062	3,798
NHS and Department of Health	30,017	1,174
Local Government	120	82
Central Government	334	1,292
Total	33,533	6,346

29 Losses and special payments

	Group / Trust			
	31 March 2020	**31 March 2020**	31 March 2019	31 March 2019
	Number	**£'000**	Number	£'000
Losses				
Losses of cash due to:				
Bad debts and claims abandoned	**10**	**105**	20	741
Total losses	**10**	**105**	20	741
Special Payments				
Ex gratia payments in respect of:				
Loss of personal effects	**34**	**6**	11	1
Other negligence and injury	**-**	**-**	-	-
Patient referrals outside the UK and EEA guidelines	**-**	**-**	-	-
Total special payments	**34**	**6**	11	1
Total	**44**	**111**	31	742

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.

30 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 2020. Estimates are based on the Foundation Trust's current understanding of the actual committed expenditure.
- An estimate of £1.3 million is made in relation to the income due from incomplete patient spells as at 31 March 2020 as the true income in relation to these episodes of care will not be known with certainty until the patient is discharged. This estimate is based on historic trend analysis, together with other relevant factors.
- An estimate is made for depreciation and amortisation of £8.9 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 £4.5 million has been charged to the revaluation reserve, with a further £3.2 million included within operating expenses. This reflects the full valuation of Trust land and buildings carried out by the Trusts external valuers.
- The valuation exercise was carried out in November 2019 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19.

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

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

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

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

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

Of the £154.46m net book value of land and buildings (including dwellings) subject to valuation, £151.8m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

A 1% change in the valuation would have £1.54m impact on the statement of financial position with a £54,000 impact on the PDC dividend due to be paid next year and accrued in these financial statements.

31 Senior manager remuneration

Directors' remuneration totalled £1,170,000 in 2019/20 (2018/19 : £1,410,000). Full details are provided within the Remuneration Report.

32 Senior manager pension entitlements

There were benefits accruing to four of the Foundation Trust's Executive Directors under the NHS Pension Scheme in 2019/20. Full details are provided within the Remuneration Report.

33 Charitable Fund Reserve

The Charitable Fund Reserve comprises:

	31 March 2020	31 March 2019
	£'000	£'000
Restricted funds	**2,279**	2,152
Unrestricted funds	**1,135**	1,205
Total	**3,414**	3,357

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

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

Christchurch Hospital
Fairmile Road, Christchurch, BH23 2JX

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