NHS
Southern Health
NHS Foundation Trust

Annual Report and Accounts
2019/20
Southern Health NHS Foundation Trust









OUR VALUES

Patients & people first

Partnership

Respect

Southern Health NHS Foundation Trust
Annual Report and Accounts 2019/20

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

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1.1 FOREWORD BY THE CHIEF EXECUTIVE AND CHAIR

Introduction by Nick Broughton, Chief Executive

This has been one of the most significant years in the Trust's recent history. It has been one of improvement and consistent progress and one that moves us closer to achieving our potential.

After a number of years of intense focus, learning and improvement, the Trust was rated 'Good' overall by the CQC in January 2020 following an inspection in October 2019.

The Trust still has further to go to become the outstanding organisation I believe it can be. However, it is absolutely right, when looked at in the context of its recent history, that we celebrate this achievement. In particular, we must recognise and congratulate our staff who have worked tirelessly to improve services. Their commitment and dedication is one of the key reasons we have achieved this improved rating which is testament to their hard work. Of course, as an organisation we are absolutely committed to ongoing improvement and we are very aware that there is more to do. Nevertheless, it is heartening to know that the Trust is heading in the right direction.

Over the last 12 months I have been particularly encouraged by the way Southern Health has made significant connections with the local community and collaborated with individuals and organisations who share our values. One example of this is our Suicide Prevention Strategy. Key parts of our strategy were informed by those who had lost someone to suicide. Indeed, the steering group is chaired by Roger Colvin, who lost his wife, Theresa, to suicide whilst under the care of our services in 2012. I first had the privilege of meeting Roger in 2018, at Oxford Crown Court where the Trust was being prosecuted by the Health and Safety Executive in relation to Theresa's death and that of Connor Sparrowhawk. In September 2019, with Roger's support, we launched our Every Life Matters campaign as part of World Suicide Prevention Day. A key part of the campaign were our 'Life Cards' – a simple and discreet card containing different support services someone could call in a crisis. Over **34,000** cards have now been requested by a diverse range of organisations, including the Maritime and Coastguard Agency, London Fire Brigade and British Transport Police alongside our local health and social care partners across Hampshire. Through social media, the campaign was able to reach over 1million people. Whilst it was undoubtedly difficult to hear how we had failed someone, I was very proud that we have been able to work alongside Roger in order to improve our services, and I am immensely grateful to him for the support and challenge he has provided.

Throughout the year we have continued with our Quality Improvement programme, embedding a systematic approach to transforming our services. The work, I believe, has brought about a fundamental change in our culture and staff now genuinely believe continuous improvement can be a part of everyday practice. We now have over **100** certified quality improvement leaders and **193** practitioners. Over **1500** staff have taken part in projects which equates to a quarter of our workforce. I am particularly pleased that we have also involved over **250** service users, demonstrating our absolute commitment to involve and learn from the people we support whenever possible.

Following on from this, our involvement of service users, carers and families has seen consistent progress over the last year. We continue to embed the Triangle of Care across the Trust as well as finding new ways to engage people who we have previously struggled to reach. A great example of this was our work with young people and Unloc which not only reached hundreds of young people but led to great partnerships with the education sector, national charities in Time to Change and a nomination for a Health Service Journal award.

One of our top priorities over the last two years has been to reduce the use of out of area placements for patients requiring mental health care. Sending patients miles away from their family and friends for treatment, is a serious issue affecting many mental health providers across the country. Aside from the very obvious impact this can have on a patient, there are significant cost implications. Indeed 2018/19 saw us spend **£12.6m** on out of area placements; this high level of expenditure continued into the first part of 2019/20, with a peak in July with a monthly spend of **£1.5m** and total annual expenditure of **£14.4m**. To address this we implemented a 'Divisional Bed Management' system, essentially giving each division greater control over their own bed stock rather than it being centrally managed. At the end of July 2019 just after fully launching the new system we had **64** people out of area and a further **16** in extra contractual beds provided by a partner organisation. By the end of March 2020 this had dropped to just two people being treated out of area with **25** in extra contractual beds. We know we still have much work to do on this so it is vital that we continue to assess changes to quality and patient experiences and empower our staff to make the best decisions for their patients.

In September 2019, we were very pleased to open a new low-secure hospital for young people with mental health problems. Austen House, on the Woodhaven Hospital site at Tatchbury Mount, is a state of the art unit designed with the input of the young people who use it. There is a shortage of this type of service in the UK, which can sadly lead to young people receiving care far from home for long periods. So I am delighted that we have been able to significantly increase access to this vital service for young people across the South. Together with our medium secure unit, Bluebird House, Southern Health is now able to provide more of the secure care pathway for young people, which will improve patient experience and provide more opportunities for step-down and rehabilitation locally.

As part of their inspection in October 2019 the Care Quality Commission (CQC) considered whether the organisation was 'Well-led'. The findings were encouraging and we were rated as being "Good" in this domain. The CQC noted significant improvements in leadership and culture compared to the previous inspection. During the course of the year we welcomed new Board members to the Trust which have further strengthened our senior leadership. Grant MacDonald and Heather Mitchell joined us as Chief Operating Officer and Director of Strategy, respectively. Both colleagues have brought a wealth of experience and expertise. We also appointed to senior clinical roles reinforcing our commitment to clinical leadership. In addition, our Deputy Chief Medical Officer, Dr Mayura Deshpande, was appointed to the position of National Clinical Advisor for Secure Mental Health Services within NHS England.

Leadership happens at every level and helps to build the right culture, so I am also pleased that this years' National Staff Survey revealed further improvements to staff engagement levels. Staff engagement and culture remain top priorities for the Trust because they are such potent drivers of care quality and patient experience. This year we updated our People and Organisational Development strategy, which sets out how we are going to do this and measure our progress in the years to come.

Whilst there is clear evidence and recognition that care at Southern Health has improved, we must continue to reflect on past failings, keep learning and making our services better. This year we sought the support of NHS Improvement to help address understandable and longstanding concerns from a small number of families whose loved ones sadly died whilst under the care of the Trust between 2012 and 2015. This led to an independent review by Nigel Pascoe QC and a report which was published in January 2020. The report makes for very sobering reading and highlights a number of incidents where the Trust clearly got things badly wrong. We have apologised to the families involved for these failings and thanked them for taking part in the investigation. The Trust remains committed to taking part fully in any subsequent proceedings, which may help family members get the answers they need.

As I write this the Trust, the NHS and wider society are in the midst of the global Covid-19 pandemic and my heart goes out to all those who have lost loved ones or who are struggling with the effects of lockdown.

This is without a doubt the greatest health challenge we have faced for a century and it will continue to drive our work for many months, if not years, to come. I am immensely impressed with the response from colleagues at Southern Health, which I believe is testament to the strong and supportive culture we have collectively nurtured over recent years. A huge amount of work has taken place to prepare and change our services, and indeed transform the way we work, in a very short time. Colleagues have come together, working beyond their usual practice, to meet this challenge head on. We have also been humbled by the outpouring of support from our local communities in terms of volunteers, donations and the simple but powerful act of clapping.

In the weeks and months ahead the Trust must ensure it is ready to support local communities and staff to recover from the effects of this event which is unprecedented in our lifetime. The word 'crisis' means a 'decisive moment' – a turning point from which positive change can come. It is crucial that Southern Health and the wider NHS learn from our response to this crisis; that we retain and build upon the step-change in collaboration, the better use of technology, and the ability to get things done with the minimum of delay. If we do this we will, I firmly believe, be able to improve significantly the care and experience for our patients for many years after the Covid-19 pandemic has ended.

In May 2020 I was due to leave Southern Health to take up the position of Chief Executive at Oxford Health NHS Foundation Trust. However, due to the Covid-19 outbreak I have taken the decision to stay on at Southern Health until June 2020 to provide stability and continuity within the leadership team at such an uncertain time.

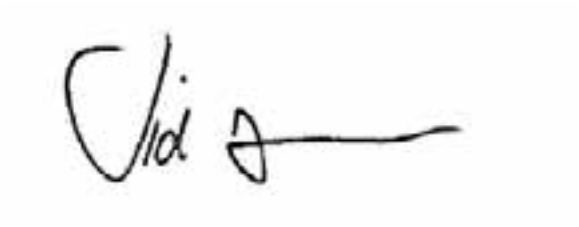
I have greatly enjoyed my time at Southern Health, and have worked alongside many, many great people both within the Trust and in the wider health and care system in Hampshire. The role at Oxford Health is a fantastic opportunity (not least because I live in Oxfordshire) but I will nonetheless be very sad to leave Southern Health. It will always have a special place in my heart.

I would like to thank all our staff for their achievements and commitment to improving the Trust during my time here, we would not have achieved what we have without their tireless commitment and endeavour. I would also like to thank my colleagues on the Board for their consistent support, and when needed, meaningful challenge which has enabled us to improve the Trust. Great healthcare is all about great teamwork and I firmly believe that Southern Health is a great team and one that will only become stronger.

Finally, I would like to thank every patient, service user, family member, colleague and partner who has provided any feedback, comment, compliments, criticism or complaint. This has served to only increase our desire and commitment to improve the care we provide.

Once again, thank you and I look forward to following the progress of the Trust as it continues its journey towards becoming an Outstanding organisation.

Signed:



Dr Nick Broughton, Chief Executive

2 June 2020

Introduction by Lynne Hunt, Chair

On behalf of the Board, I would like to open by saying a huge thank to all our staff for their hard work and commitment over the last year, and in particular, for rallying together over the last few months as part of the collective NHS response to the Covid-19 pandemic. The effort of all our staff has been overwhelming, and I am so touched by the many stories I have heard of staff going the extra mile to provide exceptional care for our patients and service users. For me, this has served to reinforce the observations from the CQC in our recent inspection report, in which they identified clear improvements within the Trust. This 'Good' rating is something that all staff should feel hugely proud of, it is testament to the hard work and contribution of all who work for, and with, the Trust.

This year has been one of further learning and improvement for Southern Health and I am pleased that we have been able to achieve this for the benefit of our patients, their carers and our communities.

As you will have already read in his introduction to this year's Annual Report, sadly Nick is moving on. I would like to take this opportunity, both personally, and on behalf of the Board, to thank him for everything he has done in driving this Trust forward. Nick joined the Trust at a real turning point in its history. Since then he has worked tirelessly to lead improvements in our services and enable our people to achieve their potential. This was highlighted when, for the first time in the Trust's history, it achieved a 'Good' rating with the CQC in January this year. Whilst all of us on the Board will be sad to see Nick go, he leaves the organisation in great shape. We are also pleased that in his new role as Chief Executive at Oxford Health NHS Foundation Trust, Nick will continue leading NHS mental health and community services in the wider region.

Thank you Nick: we wish you well.

I am very pleased to announce our new Chief Executive, Ron Shields. Ron joins us in June 2020. Ron's previous role was as Chief Executive at Dorset HealthCare University NHS Foundation Trust, a mental health and community Trust that he led to achieve an outstanding CQC rating. Ron has considerable experience and a real demonstrable commitment to championing the interests of patients. I am looking forward to working with Ron as we continue on our own journey of improvement.

Whilst our new CQC rating reinforces the evidence that we are improving, we know there is still much for the Trust to do.

I have no doubt that we can become an 'Outstanding' Trust but that we cannot achieve this on our own. It will take the combined efforts of all our staff, senior leaders and our many partners, and the input and insights of the people who use our services, their families and communities. However I am certain that we can reach this goal and I am keen that we build upon the momentum gained from our positive rating and push on towards become Outstanding.

A vital part of our work over the last few years has been the role our Governors, members, families, carers, carer support organisations and patient participation groups have played as we have moved forward. Our Governors not only provide us with the link between the communities we serve and our services, but also the scrutiny and challenge the Board needs as it works to keep improving. Alongside this we must continue to engage with families and patients through our membership and various patient participation groups. The voices and feedback we have heard through these continues to be embedded into our services as we look to enable true co-design with patients at the heart of what we do. This work would not have been possible without some of our colleagues using their lived experience to improve our services. Our involvement of people with lived experience can be seen in our Quality Improvement (QI) work. I am pleased to note that over **250** service users have been involved in this work, helping our teams find new ways to work and improve their services. Over the last two years we have worked hard to roll out the QI work.

Our challenge now is to ensure that work is embedded within those teams and the wider Trust. It is vital that we do not lose the momentum we have gained with this work and that a culture of improvement becomes engrained within the Trust.

A core aim for me is to move the Trust forward to become a University linked Trust and the System leader I believe it can be. We can only achieve this if we continue to push ourselves forward. In my time here, I have seen that we are more than capable of providing the type of clinical excellence needed to achieve this. However, our challenge is to do this consistently, across all our services. To do this we need to continue to strengthen our divisional structures and work with our colleagues across the sector, and for me, this includes working alongside my fellow Chairs.

I would like to echo Nick's thanks to all the people who have worked with us, supported us and provided the feedback we have needed to improve our services. In particular, this includes our Mental Health Act Review Managers, who undertake a vital role on behalf of the Board ensuring the rights of our service users are upheld.

Personally, I would like to thank all my Chair colleagues across Hampshire and the Isle of Wight for working tirelessly to improve the health of our local populations, and in particular, Lena Samuels, Chair of the Hampshire and Isle of Wight Sustainability and Transformation Partnership (HIOW STP), for her never failing support.

As I have already mentioned, towards the end of the period covered by this report, the UK was struck by the Covid-19 pandemic. At the time of writing this, we are still very much enmeshed in the crisis, which has transformed all our professional and personal lives in fundamental ways. I have been humbled to witness the response from my colleagues in Southern Health and the wider health and care sector to this unprecedented challenge. It has been nothing short of staggering, in terms of the scale of change and preparation, the level of collaboration and teamwork, and the unswerving commitment to patient care throughout. On behalf of the Non-Executive Directors, I would like to recognise and thank our Executive colleagues for the leadership and commitment shown during this difficult period.

Already, our thoughts are turning to the weeks and months ahead. The work to recover and prepare for the aftermath is already beginning and will be a core priority for the Trust and the whole NHS. Ensuring we have the right services in place to respond to the short, medium and long term effects this pandemic will have on our communities will be crucial. We must ensure we support our staff to maintain their wellbeing now, and in the months ahead. They have been phenomenal and as a Board, it is our job to make sure we do right by them.

As a Foundation Trust, our Council of Governors is a key part of our governance structure. For me, understanding and recognising the invaluable contribution that our Governors provide, and nurturing and developing a constructively challenging relationship between the Governors and the Board has been integral to our success in driving forward improvements. I would in particular like to recognise the input of Andrew Jackman, our Lead Governor, whose term of office as a public Governor will conclude in July this year at the end of a nine-year term. I am delighted that Andrew has agreed to share his reflections and observations of the Trust during his tenure as a Governor, which I feel candidly reflects the journey that we have been on, and indicates the optimism for our future:

"I am nearing the end of my third term as a public Governor for Southampton, and for much of this time I have also been the Trust's Lead Governor, re-elected several times by my fellow Governors. I have worked alongside six Chairs and soon to be five Chief Executives (in both

cases including interim roles) and have seen enormous change.

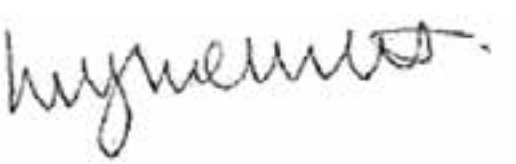
In 2016 I was contacted by Monitor directly, when they formally invoked their powers to require the Trust to make changes to the Board of Directors. In 2015 The Trust had been, quite properly, rated as "Requires Improvement" by the CQC.

The last three years has seen an emphasis on Trust values, putting patients at the centre of everything we do. Under the inspiring leadership of Lynne and Nick we have seen a relentless drive towards quality improvement, openness and transparency. Words like kindness and compassion have been heard far more often than before, but words like performance and grip are also often heard, as is right. I am writing this six weeks after the Prime Minister imposed lockdown due to the Covid-19 pandemic; as a Governor and in my role as a Trust Mental Health Act Review Manager I have seen the Trust leadership meet the challenge of a lifetime head-on, and they have not been found wanting.

The journey to our current Good CQC rating has been hard and the Board is now set on achieving an Outstanding rating in due course, focusing always first and foremost on our patients; I believe that the groundwork has been set for this to be achieved."

In conclusion, I would like to recognise the progress made in 2019/20; this has been a year of great improvement and change, as described by Nick, and also recognised within my opening paragraphs. I would like to thank all of my Board colleagues for their role in this. Looking ahead to 2020/21, I am confident that we have plans in place to help us continue on our journey to become an outstanding and clinically excellent organisation.

Signed:



Lynne Hunt, Chair

2 June 2020

1.2 PERFORMANCE OVERVIEW

Who we are and what we do

The purpose of this overview is to understand Southern Health, our purpose, key risks and how we have performed during the year. Southern Health NHS Foundation Trust is the main provider of community health, specialist mental health and learning disabilities services for people across Hampshire.

This year our staff cared for **215,013** people and served a population of **1,748,258** people (compared to around **280,000** people in 2018/19).

We delivered **201,044** outpatient appointments and patients received care in our hospital beds for a total of **225,157** days; this compares with **206,226** outpatient appointments and **211,235** bed days in 2018/19 (2018/19 figure restated to ensure like for like comparison). We provided **1,158,426** contacts with patients in the community this year, compared to **1,144,118** last year (this includes providing care to patients in their own homes). We cover a large geographical area and operate from 300 sites including community hospitals, health centres, inpatient units and community based services.

As a Foundation Trust, we have **8341** public members from local communities. Our members elect a Council of Governors, which holds our Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

We are funded by NHS England, local commissioners and local authorities receiving around **£300m** each year.

Our services cover:

- treatment and support to adults and older people experiencing mental illness in the community and through our inpatient services
- treatment for adults and young people in secure and specialised settings delivered in conjunction with multiple provider collaboratives
- IAPT (Improving Access to Psychological therapies) services
- community learning disability teams working in partnership with local councils to provide care and support for adults with learning disabilities
- specialist learning disability inpatient services
- a diverse range of community health services providing care to both adults and children. This encompasses community nurses, end of life care, safeguarding, diabetes services, speech and language therapy, stroke services, X-ray, pain management, Orthopaedic Choice, physiotherapy and podiatry
- health visiting and school nursing teams working to deliver the Healthy Child Programme across Hampshire.

Our history (in brief)

In 2009 we gained Foundation Trust status under the name of Hampshire Partnership NHS Foundation Trust. On 1 April 2011 we become Southern Health NHS Foundation Trust following a merger of Hampshire Partnership NHS Foundation Trust and Hampshire Community Healthcare. In November 2012 we acquired Oxfordshire Learning Disabilities NHS Trust which enabled us to provide learning disability and social care services across Oxfordshire, Buckinghamshire, Wiltshire and Dorset. In 2016/17 the services that were acquired in 2012 were transferred to other providers allowing us to focus on services provided within Hampshire. In 2017/18 following regulatory intervention, which resulted in significant changes to the leadership of the Trust, a commitment was made by the Board to continue providing both mental and physical health services, with an aim of providing more joined up (integrated) care. In 2018/19, the Transformation and Quality Improvement programme was launched, and the process began to restructure the organisation into geographical divisions with cross-Hampshire services remaining as a standalone division.

What drives us

For us to become the healthcare provider our patients deserve, it is crucial that we have:

- a clear aim of what we aspire to in our vision and purpose statements
- a shared set of values that underpin everything we do
- agreed strategic priorities that set out what we need to do deliver our vision

Our vision

World class treatment and care, together.

Our purpose

Holistic care in partnership that improves lives.

Our values

In 2017 we worked closely with our staff and partners to develop a refreshed set of values. These are the core principles that underpin everything we do, from ward to Board. Our values are:

- Patients and People First
  - Providing compassionate, safe care
  - Listening to each other
  - Doing the right thing
  - Appreciating each other
  - Delivering quality
- Partnership
  - Communicating clearly
  - Supporting each other
  - Working as a team
  - Building relationships
  - Making things happen
- Respect
  - Acting with honesty and integrity
  - Respecting each other
  - Taking responsibility
  - Getting the best from our resources
  - Doing what we say we will do

Our strategic priorities

Our strategic priorities support the delivery of our purpose and define what we will do to deliver our vision. Overleaf are the five-year strategic priorities for 2019/20 to 2023/24. These were launched during the summer to ensure every member of staff could incorporate them into their appraisals and help us achieve our vision:

- Improve health and wellbeing through outstanding services
- Become the best employer
- Transform services through integration and sustainable partnerships
- Improve value

Overleaf is a diagram showing our five year strategy and how the vision, purpose, and strategic priorities come together.

Our five-year strategy

NHS
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Vision
Our ambition

World class treatment and care, together

Purpose
Why we exist

Holistic care in partnership that improves lives

OUR VALUES

Patients & people first | Partnership | Respect

Strategic priorities What we will do to deliver our vision	What will success look like? By 2024 we will have achieved:	Key actions we committed to take in 19/20 In year one we agreed to deliver:
Improve health and wellbeing through outstanding services	• An outstanding CQC rating that creates confidence in our services • A culture of continuous quality improvement • Top 10% rating nationally for patient safety, experience and outcomes • Measurable reduction in suicide of people who rely on our services	• Our CQC, regulatory requirements and quality priorities • A zero suicide approach and full implementation of the Triangle of Care • Elimination of mixed sex accommodation • Six quality improvement (QI) coaches, 60 trained facilitators, 600 staff actively involved, 6000 staff engaged, 12 QI projects delivered • Greater positive participation of people in their care
Become the best employer	• A vacancy rate of 5% • Reduced violence and harm towards staff by 50% • A workforce that is representative of our local community at all levels • Top scores in the NHS staff survey • Leadership for mental health across the Hampshire and Isle of Wight system • Capacity and capability to deliver priorities	• New Trust structure to support collective, devolved leadership and system working • Competency based workforce plans with new roles and models of care that reduce vacancy levels • Improved staff engagement across the organisation • Increased employment of people with lived experience
Transform services through integration and sustainable partnerships	• Innovative care for children and young people • Whole person, evidence-based care for the populations we serve • Improved access for people in crisis	• Redesign of secure and children's services • Improved crisis care, single point of access and national standards in mental health care • Improved community services across Hampshire • A plan for needs-led, integrated physical and mental health services • A plan for services based around primary care • Integrated intermediate care for frailty and long term conditions
Improve value	• No patients receiving care out of area • Efficient and effective use of resources and improved outcomes as a result • Reduced variation in practice and waste	• Reduced use of beds through improved community services, rehabilitation and accommodation • New pathways for dementia, psychosis and perinatal services • Our financial targets including cost improvements • Effective use of our estate and digital solutions

HOW WE'RE STRUCTURED

Structure of our Board

The Board is made up of our Executive Directors (paid employees who are responsible in their executive role for managing the organisation and, as board members, for the leadership and direction of the Trust) and Non-Executive Directors (who do not have a managerial role but are responsible for challenging the Executive Directors in decision-making and on the Trust's strategy). Collectively they are responsible for our overall performance and our plans for the future.

We also have a Council of Governors (staff, public and appointed), who represent the views of Foundation Trust Members. Governors help the Trust make decisions about our services and hold our Non-Executive Directors to account.

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Our Divisions and Main Sites

Specialist Division

Bluebird House	Medium secure forensic inpatient Child and Adolescent Mental Health (CAMHS) unit for young people with complex mental illness
Southfield	Low secure forensic unit for adults with serious mental illness
Austen House	Low secure CAMHS unit providing care for young people with mental illness
Ravenswood House	Medium secure unit providing care for adults with serious mental illness
Leigh House	Inpatient CAMHS service for young people with acute mental illness
Learning Disability services	Forensic service at Willow Ward, Moorgreen Hospital
Children's services	School nursing, health visiting and family nurse partnerships

South West Hampshire Division

Moorgreen Hospital	Stoneham centre, Southampton Intensive support team
Romsey Hospital	Radiology, orthopaedic choice, musculoskeletal (MSK), rehab ward
Fordingbridge Hospital	Ford Ward, physiotherapy, orthopaedic choice and occupational therapy
Lymington New Forest Hospital	Deerleap Ward, Longbeech Ward, frailty, MSK and radiology
Melbury Lodge*	Kingsley Ward, Mother and Baby unit and Stefano Olivieri unit

*Melbury Lodge is geographically located in the Mid & North Hampshire Division, but under operational management of the South West Hampshire Division

Mid and North Hampshire Division

Parklands Hospital	Beechwood Ward, Elmwood Ward, Hawthorns 1 and Hawthorns 2
Alton Community Hospital	Anstey Ward
Avalon House	Community hub (Older Persons Mental Health (OPMH), Community Mental Health Teams (CMHT), health clinics, community care)

Southampton Division

Antelope House	Trinity Ward, Saxon Ward, Hamtun Ward, Psychiatric Intensive Care Unit (PICU) and Crisis Lounge
Western Community Hospital	Beaulieu Ward and Berrywood Ward
Crowlin House	Social care unit providing residential care for adults with mental illness
Forest Lodge	Residential unit for people who have been using mental services who need help with their recovery and wellbeing

Portsmouth and South East Hampshire Division

Elmleigh Hospital	Inpatient service for male and females with functional mental illness
Gosport War Memorial Hospital	Rose Ward, Poppy Ward, Ark Royal Ward and Sultan Ward
Fareham Community Hospital	Continence Service
Petersfield Community Hospital	Rowan Ward, Cedar Ward, Laurel Assessment Unit, Out Patients Physiotherapy and Minor Injuries Unit
Hollybank	Residential unit for people who have been using mental services who need help with their recovery and wellbeing
Willow Group	A group of four GP surgeries in Gosport which form the Gosport Central Primary Care Network

Operational Structure

As at 31.03.2020

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Chief Operating Officer
Grant MacDonald

Emergency Preparedness
Business Continuity and Emergency Preparedness Officer
David Batchelor

Operational Transformation
Divisional Director of Transformation - MH & LD
Graham Webb

Divisional Director of Transformation - ISD
Jane Williams

South West Hampshire Division
Clinical Director:
Dr Rachel Anderson

Divisional Director of Operations:
Laura Rothery

Medical Director:
Dr Jeremy Rowland

Director of Nursing and AHPs:
Ben Goodwin

Southampton Division
Clinical Director:
Dr Adam Cox

Divisional Director of Operations:
Sarah Olley

Medical Director:
Dr Zaid Alabbasi

Director of Nursing and AHPs:
Ann Middleton

Mid and North Hampshire Division
Clinical Director:
Dr Hazel Nicholls

Divisional Director of Operations:
Nicky Macdonald

Medical Director:
Dr Susie Carmen/Dr Mary Kloer

Director of Nursing and AHPs:
Liz Taylor

Portsmouth and South East Hampshire Division
Clinical Director:
Dr Robin Harlow

Divisional Director of Operations:
Nicky Adamson-Young

Medical Director:
Vacant

Director of Nursing and AHPs:
Julia Lake

Specialist Services Division
Clinical Director:
Dr Mayura Deshpande

Divisional Director of Operations:
Rob Guile

Medical Director:
Dr Amanda Taylor/ Dr Jim Ormsby

Director of Nursing and AHPs:
John Stagg

The structure of our services

The Trust is split into four geographical Divisions (Portsmouth and South East Hampshire, West Hampshire, Mid and North Hampshire and Southampton City). There is a fifth division which encompasses our specialist services such as children's services, learning disability services and forensic services. These divisions are supported by shared corporate service resources.

The Divisions are aligned to the local health systems within our geographical areas as well as the **34** Primary Care Networks. They cover both physical and mental health services and are led by separate leadership teams headed up by a Clinical Director who continues to work in their own clinical speciality.

Effectively managing our risks

We carefully identify, monitor and manage risks which may impact on our ability to continue providing care. We do this through a detailed risk register and our Board Assurance Framework. Our most fundamental risk is that we fail to provide high quality or effective care, resulting in serious harm. In addition, we have identified risks which relate to our ability to recruit and retain staff, provide a positive experience of our services for patients, deliver truly integrated services, or achieve long term financial sustainability.

Alongside these high-rated strategic risks, we continue to focus on the quality and effectiveness of our services, patient and service user engagement, culture and values, the effectiveness of our governance structures, and our ability to manage organisational change. These areas are the next highest scored risks in the Board Assurance Framework.

More information on the risks and how we manage them can be found in the Annual Governance Statement, from page 126, and further detail on delivery of our strategic priorities in 2019/20 is set out in the Performance Report on pages 32–54.

Research at Southern Health

Within Southern Health, we encourage a culture of research in the organisation that enables every patient and clinician the opportunity to participate in research. There are a number on-going trials, both at local and international level which are key to improving patient care and outcomes.

We actively involve patients, service users, carers and staff in research projects. This year a total of 1907 patients and staff participated in research projects. We also work closely with our key stakeholders namely, the National Institute for Health Research (NIHR), and local and national research networks such as the Clinical Research Network Wessex; the Academic Health Science Network (AHSN) and academic institutions.

Further information about the research we do can be found on our website at:
https://www.southernhealth.nhs.uk/services/research/research-and-development/

Our Memory Assessment and Research Centre (MARC) is an internationally recognised research unit, established over thirty years ago, which has made significant contribution to the understanding and treatment of dementia and cognitive impairment – with a specific focus on finding a treatment to slow the progression of memory decline and improve quality of life.

Our response to Covid–19 and the impact on our services

Covid-19 has had a huge impact on everyone's lives and the NHS has seen a large impact on our services. For Southern Health this has seen us provide services in new ways such as via video links and telephone. Staff were redeployed to help services most impacted and help with community testing. We are incredibly grateful to all our staff during this pandemic, their attitude and dedication has seen the Trust respond well and continue providing care in the best possible way.

Our Covid-19 steering group was convened on 7 February 2020 to provide the initial co-ordination of our response. This included working with system partners to mobilise Covid-19 Priority Assessment Pods and subsequently the commencement of a community testing service (4 March 2020).

Regular and clear communications were essential to keeping our staff updated and informed and focused on ensuring that staff knew how to identify symptoms, adopt good hand hygiene and knew where to seek expert IPC (Infection, Prevention and Control) guidance. Daily messages were established and underpinned by a hub of information on our intranet including health and wellbeing information for staff and the public.

The Trust convened an incident co-ordination centre (ICC) to the emergency response reporting to the Executive Team (Gold Command). This provided a mechanism for escalating risks and threats, providing situation reports, and receiving direction at local, regional and/ or national level as well as providing an interface with the multi-agency health and social care cell within Hampshire and the Isle of Wight.

We also modified our wider governance structures to ensure we can focus resource where needed. The committee structure was adapted; some committees suspended and other groups established including a clinical ethics group and IPC group.

The Trust had to make the difficult but necessary decision to close its wards to visitors, but at the same time has implemented technological alternatives to ensure patients and families can still stay in touch with loved ones. Ward based activities have also been enhanced through technology as well as more traditional activities being provided, many of which have been generously donated. As the Trust looks towards the next steps of restoration and recovery, there are many opportunities for providing services in different ways and embedding the positive changes throughout 2020/21.

Going concern disclosure

These accounts have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management intends, or has no alternative but, to apply to the Secretary of State for the Trust's dissolution without the transfer of its services to another entity.

The Trust reported a deficit (on a control total basis) of **£5.7m** for 2019/20, an adverse variance of **£6.3m** to the revised control total of **£0.6m** surplus. During 2019/20 the Trust successfully secured revenue support, in the form of a loan, of **£5.0m** which enabled the year end cash balances to be higher than planned.

For 2020/21 the Trust had originally planned an agreed deficit within the Hampshire and Isle of Wight Integrated Care System which required **£11.4m** of support from NHS Improvement to be provided to enable a breakeven position. On top of this there was the need for a challenging cost improvement plan which, within the context of responding to Covid-19, would be more difficult to deliver. Although there is an ongoing national commitment to Trusts who are in difficulties with cash, this is applied for and approved in year when the need arises.

Following the declaration of the pandemic, revised financial arrangements were put in place by NHS Improvement/ England to support the sector's response to Covid-19. This has resulted in the 2020/21 operating plan and contract negotiations with Commissioners being paused, increased flexibility on cash and no requirement to pay back loans previously agreed as revenue support. The Trust has set a financial budget for the year based on a refreshed draft plan and demonstrates a planned breakeven position. Key to this plan are the following assumptions:

- that all Covid-19 related expenditure is reimbursed
- that the financial arrangements in place for income between April and October continue until March 2021 that include, where required, a monthly top up to breakeven or alternative arrangements that achieve the same
- that where identified cost improvement plans that do not compromise the organisation's response to Covid-19, are implemented
- that quality improvement schemes such as the reduction in out of area placements will continue at pace to ensure that spend in these areas is reduced to levels below 2019/20
- a recurrent recovery plan for 2021/22 to be developed aligned to system requirements, linked to reasonable income assumptions from Commissioners for 2021/22, taking account of the ongoing Covid-19 response and future pressures and ways of delivering services
- capital schemes for the Trust will be managed within **£10.2m** (limited by the financial envelopes allocated to the Hampshire and Isle of Wight Integrated Care System) and local cash restraints
- planned closing cash balance of **£9.5m** at the end of June 2021 which demonstrates adequate cash resources through to this date
- continued commitment from the Secretary of State to provide cash support when organisations require it to maintain adequate liquidity.

In accordance with IAS 1, the Directors have made an assessment of the Trust's ability to continue as a going concern considering the significant challenges described above. These factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. The Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. This is supported by the "Statement to Support Forecasting" issued by NHS England and NHS Improvement on 27 May 2020. For this reason, they continue to adopt the going concern basis in preparing the accounts and the financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

OUR YEAR 2019/20

April 2019

- We launched a 12 month pilot offering expert advice, assessment and support for young people and adults experiencing mental health problems. The service is 24/7 and access via NHS 111.
- The Willow Group (our group of GP practices based in Gosport) achieved a Good rating with CQC.
- Our Specialist Falls Prevention team were shortlisted for a Patient Safety Award for the Best Partnership Solution Improving Patient Safety alongside Hampshire County Council and Hampshire Fire and Rescue Service. The organisations have been working in partnership as a Better Balance Network, delivering a range of classes that promote balance, staying strong and independence at home to older people.

May 2019

- The Trust became a smokefree organisation which means that staff, patients and visitors are no longer able to smoke on any of our sites.
- Our Mother and Baby unit in Winchester took part in a Louis Theroux documentary. Called 'Mothers on the Edge', it was about post-partum mental health including post-partum psychosis.
- We re-opened Beaulieu Ward at the Western Community Hospital in Southampton after an extensive refurbishment. The ward now provides the best possible environment for dementia patients.

July 2019

- Southern Health linked with the military charity, Help for Heroes and Sparsholt College's horticulture team (winners of numerous gold medals at the RHS Chelsea Flower Show) to plan a transformation of the tired, under-used outside spaces at Parklands Hospital into a special sensory garden for military patients and a second more social, active outdoor space for other patients and visitors. We would like to thank everyone that has donated to this project to help make it a success. This includes the ABF Soldiers Fund, Armed Forces Covenant, RAF Benevolent Fund and Hampshire County Council.
- Our North and West Hampshire Respiratory Service was awarded runner up for 'Respiratory Team of the Year' at the Association of Respiratory Nurse Specialist Conference. The team was rewarded for its high quality treatment of patients with pulmonary conditions.
- The Trust commenced transfer of our Quit4Life service to Solutions4Health who were successfully awarded the contract for smoking cessation services across Hampshire.

August 2019

- We hosted a stand at the Southampton Pride event to pose the question 'HowRUToday?' to pride-goers with the aim of opening up a conversation about mental health. Clinicians were available to talk to those who recognise they need support, as well as contact cards to take away with them.
- The Trust was shortlisted for 'Outstanding Commitment to Sustainable Service Development' at the Royal College of Psychiatrists Awards. A number of our teams volunteered to implement initiatives to reduce local air pollution – and, after just five months, they saved **16,481kg** CO_2e from their business travel and **5,735 kg** CO_2e from commuter travel.

September 2019

- We opened Austen House, a low secure, forensic hospital that provides vital support for children and young people with specialist mental health needs, in the South of England and beyond. The 14 bedded hospital underwent a **£7m** refurbishment and supports some of the most vulnerable young people in society.
- To coincide with World Suicide Prevention Day we launched our suicide and self-harm prevention Strategy 'Every Life Matters' with the production of 'Life Cards'. The cards signpost people to key organisations that offer advice, help and support to people who are having suicidal thoughts. They also link to free vital resources and suicide prevention training to equip people with the skills and confidence that could help save someone's life.
- We hosted our Annual Members' Meeting at The Ark in Basingstoke – asking attendees "what's important to you?" The event focused on how the Trust has been transforming services by engaging with patients and carers over the past year.

October 2019

- To coincide with 'Restart A Heart' Day (run by the Resuscitation Council UK), we trained upwards of **2500** children between the ages of 7 and 16 years old – including **1360** secondary pupils at Horndean Technology College, plus four junior schools and a school for special educational needs, in life-saving CPR techniques.
- Working in partnership with Hampshire commissioners and the three Hampshire acute hospitals – Southern Health has successfully bid for national funds to increase psychiatric liaison (mental health in-reach) into Hampshire's four acute general hospitals.

November 2019

- We launched a Future Planning template, encouraging people to make a note of their wishes in the event of their lives ending. Often, in a crisis, clinical teams caring for someone have scant information about a patient or their wishes. The template enables GPs to record a person's care wishes and have them shared with key services.
- The midway results of our pilot to reduce restrictive practice at Bluebird House showed a **67%** reduction. The programme uses innovative methods to deliver the reductions such as patients writing their own care plans and 'here to help' staff available to talk on the ward.
- Crowlin House, our residential home for people with mental health issues received a Good rating with the CQC.
- The Trust were awarded the contract to continue to run our innovative child health services across Hampshire in partnership with Barnardo's.

December 2019

- We were awarded the contract to continue to run our successful childhood immunisation programme for school age children across Hampshire.

January 2020

- We received a Trust rating of Good from the CQC following a comprehensive inspection of four core services undertaken in October 2019. Overall **90%** of the Trust services are now rated as Good or Outstanding.
- We were shortlisted for a 'HSJ Partnership Award' for our work with UNLOC (under 'Best Educational programme'). The shortlisting recognises the Wellbeing Roadshows recently undertaken to determine which services young people understood were available to them. Feedback received from attendees has shown that the roadshows empowered the young people and encouraged positive conversations about mental health.
- The West Hampshire Community Integrated Respiratory Service is supporting nursing homes across West Hampshire by holding a series of respiratory education programmes to develop their skills and confidence in the care of respiratory patients.

February 2020

- Executive Director of Workforce, Organisational Development and Communications, Paul Draycott, was named as Stonewall's Senior Champion of the Year for the South East of England.

March 2020

- People experiencing a mental health crisis in Southampton now have access to a brand new service in the heart of the city: the Lighthouse. The Lighthouse is a safe, non-judgemental space, staffed by mental health professionals and peer specialists, who themselves have lived experience of mental health difficulties which they can draw upon to help others.
- Dr Mayura Deshpande, a psychiatrist and our Deputy Chief Medical Officer, has been appointed to a prestigious new national advisory role. In addition to her position within Southern Health, Dr Deshpande is now National Specialist Advisor for Secure Care.
- Staff at our secure adolescent psychiatric unit, Bluebird House had the privilege to work with the charity 'Hospital Rooms' on a special project to transform some of the environments used by our young patients. Hospital Rooms is a charity that works with upcoming and well-known artists to create new and exciting spaces in various psychiatric facilities across the country.
- The Trust were awarded the contract to continue to provide the Child Health Information Service which manages data transfer between 0–19 teams, GPs, midwifery and education services to inform and share information about all children born or transferring in to Hampshire to ensure clinical services are offered to all children, safeguarding their health and wellbeing.

1.3 PERFORMANCE ANALYSIS

We are generally performing well against our regulatory and contractual targets for the people who use our services. We are also performing well against our internal targets. We have some areas where focused improvement is required and have plans in place to achieve these.

Below is a summary of our targets for our mental and physical health services:

- Mental health:

Metric	Description	Priority for	Required target to achieve minimum compliance	Performance	Achieving Target (Yes/ No)
Gatekeeping	Every patient admitted to an adult mental health ward is assessed by a crisis team to ensure the admission is clinically appropriate for the patient.	NHS Improvement	Greater than or equal to 95%	98.8%	Yes
Mental Health & Learning Disabilities inpatient – delayed transfers of care	This indicator measures the percentage of patients who are medically fit to be discharged but are unable to be discharged for non-medical reasons.	NHS Improvement	Less than or equal to 7.5%	7.1%	Yes
Care Programme Approach 7 day follow up	Patients should be discharged in a safe and supported way, ensuring they receive a dedicated follow-up appointment within 7 days of a discharge from a Mental Health hospital.	NHS Improvement	Greater than or equal to 95%	97%	Yes
Early Intervention in Psychosis 2 week wait	People with a first episode of psychosis to begin treatment with a NICE-recommended package of care within 2 weeks of referral.	NHS Improvement	Greater than or equal to 50%	94.3%	Yes
Improving Access to Psychological Therapies waiting times – 6 weeks	People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral.	NHS Improvement	Greater than or equal to 75%	93.8%	Yes

Metric	Description	Priority for	Required target to achieve minimum compliance	Performance	Achieving Target (Yes/ No)
Improving Access to Psychological Therapies waiting times – 18 weeks	People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	NHS Improvement	Greater than or equal to 95%	99.8%	Yes
Waiting times – external referral clock stops	This is where a time measure for treatment is stopped because treatment has started in an external provider.	Commissioner	Greater than or equal to 90%	91.0%	Yes
Care Programme Approach 12 month reviews	The percentage of all service users on Care Programme Approach (CPA) who have had their care plan reviewed within the last 12 months and who have been on a CPA for 12 months or more. A CPA is a programme used to plan a patient's mental health care. Not all patients are on CPA.	NHS Improvement	Greater than or equal to 95%	98.5%	Yes
Mental Health service data set identifiers	Compliance of identifier elements of the Mental Health Services Data Set (MHSDS) assesses validity of entries of a core number of indicators.	NHS Improvement	Greater than or equal to 95%	99.8%	Yes
Mental Health services data set outcomes	Compliance of the outcome elements of the Mental Health Services Data Set (MHSDS) assesses validity of entries of a core number of indicators.	NHS Improvement	Greater than or equal to 50%	42.7%	No See note on page 30
Mental Health risk assessments	All mental health patients have effective and timely risk assessments.	Trust (Mental Health)	Greater than or equal to 95%	81.6%	No See note on page 30

- Physical health:

Target	Priority for	Description	Required target to achieve minimum compliance	2019/20 Whole Year Performance	Achieving Target (Yes/ No)
Referral to Treatment	NHS Improvement	% of patients on an incomplete treatment pathway with a waiting time of less than 18 weeks.	Greater than or equal to 92%	93.6%	Yes
Diagnostics	NHS Improvement	% Within 6 weeks	Greater than or equal to 99%	99.9%	Yes
Minor Injuries	NHS Improvement	% within 4 hours	Greater than or equal to 95%	99.7%	Yes
Delayed Transfers of Care	Commissioner	% of Occupied Bed Days which are delayed	Less than or equal to 14%	12.2%	Yes
End of life – dying in preferred location of care	NHS Improvement	% patients dying in preferred place of care	Greater than or equal to 80%	89.4%	Yes
Rapid response performance	Commissioner	% visits completed within 2 hour target	Greater than or equal to 80%	94.6%	Yes
Community information data set compliance	NHS Improvement	% data elemments	Greater than or equal to 50%	95.5%	Yes

Mental Health Dataset Outcomes

This year the Trust has changed the way it reports two core measures in this dataset. These are the number of service users who are on Care Programme Approach (CPA) who are in paid employment and settled accommodation. The way in which the Trust reports these measures has been updated to ensure that the status of each is regularly reviewed and updated in line with national expectations. Staff are asked to check this regularly and in some cases this is not being reflected in the electronic patient record. We are therefore working with staff to improve record keeping compliance and monitoring this at performance reviews.

Mental Health Risk Assessments

The Trust has continued to make improvements in recording compliance for this target from **74.8%** in March 2019 to **84.1%** in March 2020. Underperformance is due to data quality issues with assessments not completed in the correct part of the record and therefore not recorded as completed. Developments in our electronic record will support further improvements and the focus of audits will be on the quality of the assessment. We expect the rate of improvement to continue towards the target towards the end of the next financial year.

The availability of acute inpatient mental health care

The availability of mental health beds was a challenge during 2018/19 and this continued to be a national challenge during 2019/20. We continue to work with commissioners to ensure that Hampshire has the equivalent number of beds per 100k population that is comparable with the rest of the country.

We remain committed to providing acute inpatient mental health care to the population we serve. Our first priority is to always secure a timely admission to a setting that will meet patients' needs, and we make every effort to ensure this is within the services provided by the Trust.

Regrettably, in some cases it is necessary to secure a placement through another provider, either in Hampshire, or further afield, to make sure patients get the urgent care they need. We call these 'out of area placements'. We recognise that these are far from ideal because of the impact on patients and their families, and the additional costs of these placements. Although use in 2019/20 has been high, reflected in the overall expenditure through the year against plan, there has been significant progress made since autumn 2019 in reducing the use of these placements. Maintaining this remains a key priority for the year ahead.

More information about the use of out of area placements during 2019/20 can be found on page 49.

How we monitor performance

Further information on how we monitor performance can be found on page 133 in the Annual Governance statement.

Improvements in Data Quality

During 2018/19 we committed to make further improvements in data quality through a number of initiatives. One of the commitments for 2019/20 was to build on the foundations started on the Data Quality Kite Mark work. In order to be confident of the quality of the data we supply to all our stakeholders we have undertaken a programme of Data Quality assurance audits. A sample of patient records have been reviewed in line with the Standard Operating Procedures for recording completion of certain tasks that feed into the Key Performance Indicator reported.

Following the Organisation Change the audit programme has been reviewed to better align with divisional performance reporting and the outputs are included in the regular performance reports submitted to Trust Board.

In the following pages you will find a summary of our performance over the last 12 months in relation to our strategic priorities: Improving health and wellbeing through outstanding services, becoming the best employer, transform services through integration and sustainable partnerships and improving value.

Improve health and wellbeing through outstanding services:

What will success look like by 2024	Key actions we delivered in 2019/20
• An outstanding CQC rating that creates confidence in our services • A culture of continuous quality improvement • Top **10%** rating nationally for patient safety, experience and outcomes • Measurable reduction in suicide of people who rely on our services.	• Achievement of a Good rating for CQC • Launch of our zero suicide and self-harm prevention strategy: Every Life Matters • Working to eliminate mixed sex accommodation in our services • Building our Quality Improvement capability and continuing our Quality Improvement journey • Greater positive participation of people in their care.

Achievement of a Good rating for CQC

During 2019 we received inspections from the CQC to look at four core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICUs)
- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Mental health crisis services and health based places of safety.

They also looked at the management and leadership of the Trust. As a result of this inspection the Trust received a Good rating with over **90%** of our services now rated as Good or Outstanding. Our adult mental health wards are now in the top **25%** nationally for safety.

It also highlighted our staff as being kind, compassionate and involving patients, services users and carers. Our leadership was also pinpointed for improving culture and morale of staff. For more information about our work on staff engagement, see pages 109–115.

We know we have more work to do and are focussed on making improvements. Our main areas for improvement include:

- **Mental health services for older people** – including making changes to the environment and increasing the amount of psychological support
- **Crisis care** – we need to make more services available for this type of care. Please see page 46 for details of the Lighthouse opening within Southampton
- **Staffing levels** – this is a nationwide issue and we will be reviewing our recruitment campaigns and looking at international recruitment to try and alleviate the issues.

Overleaf is an infographic with key highlights from our CQC inspection.


CQC 2020
in numbers
NHS
Southern Health
NHS Foundation Trust
100%
rated 'Good' or 'Outstanding' in the Caring and Responsive domains
93%
of services rated 'Good' in the Safe domain
87%
services rated 'Good' or 'Outstanding' in the Well-led domain
73%
services rated 'Good' in the Effective domain

Launch of our zero suicide and self-harm prevention strategy: Every Life Matters

In September 2019 we launched our suicide and self-harm prevention strategy – Every Life Matters. The main aim of the strategy is to reduce the number of deaths by suicide of patients under the care of our services and improve our support to families and staff post suicide.

Our Suicide and self-harm prevention strategy can be accessed on our website at: https://www.southernhealth.nhs.uk/about/every-life-matters-lets-prepare-to-prevent/

The strategy focusses on raising awareness, providing suicide prevention training to all our staff, ensuring mental health patients have a safety plan and working in partnership to reduce self-harm and suicidal crisis.

Suicide prevention training has now been completed by **83%** of our staff since launching in September 2019. In addition to this we have also distributed **34,000** Life Cards to a variety of organisations across Hampshire and indeed the UK. The cards contain advice and support information for people in crisis. All emergency services across the county now have Life Cards to use internally and for frontline staff to give to members of the public. Cards have also been distributed to local schools, colleges and universities.

Working to eliminate mixed sex accommodation in our services

We have fully segregated sleeping areas, mental health and learning disability segregated day rooms, and single sex toilet and bathroom facilities in all inpatient units. We do not mix day patient care with inpatient care. The layout of some inpatient wards does lead to the crossing of corridors, through communal spaces, to access toilet and bathroom facilities. Maintaining individual patients' privacy and dignity is always a Trust priority.

It is our ambition to improve therapeutic environments and eliminate the need for people to cross corridors of communal spaces to access toilet and bathroom facilities in every inpatient unit in the Trust and to eliminate all shared 'dormitory-style' single sex accommodation across mental health inpatient units. This will require significant capital investment over the next five years to complete and will require a strong operational delivery of the Privacy, Dignity and Respect Policy.

Mixed sex breaches are reported monthly to our commissioners; in 2019/20 we reported 16 breaches over the year, with the majority of these being in our Older Persons' Mental Health Services.

Building our Quality Improvement capability and continuing our Quality Improvement journey

Last year we embarked on a Trust-wide transformation that involved the development of a Quality Improvement (QI) programme, which quickly achieved significant success and growth. This year we have focused on building our internal quality improvement capability to support the wider transformation programme. As an overview of the programme:

- **24 projects** delivered as part of training QI certified leaders
- Two larger scale transformation projects in progress and one more planned
- Over **250 service users** involved in contributing to the improvement projects through attending workshops or commenting as focus groups
- **500 staff** have received some form of QI training
- **Seven cohorts** of staff trained as QI leaders
- Created an internal resource of **six** QI Coaches
- **106** certified QI leaders
- **193 practitioners** – these are people that have received some formal QI training
- **450 foundation** – these are people that have attended a QI conference.

We developed our own training resource to reduce our reliance on Northumberland, Tyne and Wear NHS Foundation Trust, although our colleagues continue to act as mentors. This resource has allowed us to train a further three cohorts of staff as certified Quality Improvement (QI) leaders. We have now supported over **100** people through the programme, including some of our commissioners, to strengthen the understanding among our partners of what we are working to achieve.

The training programme runs over six months, which includes one week spent learning the QI philosophy and tools, and 12 weeks managing an improvement project, which culminates in a weeklong Rapid Process Improvement Workshop (RPIW). Colleagues who complete this are awarded certificates of achievement and QI lapel badges at a graduation ceremony attended by the Trust Board.

All projects have involved service users and carers where they are the effective recipient of services and this year has seen an increase in the numbers directly involved, as well the development of a training package to ensure they are well prepared to take full and equal part in the improvement projects.

This year has seen RPIWs undertaken for Southampton Community Mental Health Teams, learning disability services, therapy services at Antelope House and multi-agency discharge from Kingsley Ward. Improvement actions identified and agreed have been implemented and delivered by the certified leader fraternity, with evidence of the increasing confidence in our quality improvement approach and the skills being used to deliver transformation.

In addition to our core QI programme, we have also seen increased use of QI methodology at a grass-roots level in front line teams. We have developed QI 'Bitesize' online training to facilitate this and ensured that QI is a regular feature in Trust communications. By highlighting examples of the difference that QI has made both to clinical practice and our culture, we have seen an increase in the bottom-up adoption of QI across the Trust. An example of this is the large turnout and positive response to our QI conference. This is really encouraging and something we will continue to nurture.

Greater positive participation of people in their care

Last year we updated our 'Commitment to working with people plan 2018/2022'. It outlines our approach to engagement stating we will be inclusive, collaborative, organised, positive and proactive. We have arranged our action into four levels to ensure we seek, capture and use feedback from across the Trust:

- **Individual:** ensuring our one-to-one interactions between service users, carers and staff are based on compassion, respect and shared decision-making that leads to people feeling fully involved in their own care and treatment
- **Team/ ward:** understanding and responding to the experiences of people and their families/ carers using our services. Ensure staff have the autonomy to make changes with patients at the point of care
- **Local:** working with local communities, service users, families and carers, Healthwatch and others, to develop appropriate and meaningful services based on feedback
- **Strategic:** engaging with and listening to service users, families and carers, ensuring their views and opinions meaningfully influence the Trust's priorities and strategic direction. Employing people with lived experience in a range of roles.

Alongside the updated strategy we have developed an organisational plan for carers and families which was co-produced with our Families First group, Hampshire Carers Together and other carers groups. Our plan is aligned with the Hampshire Joint Strategy for Carers who we are working in partnership.

Progress against our strategy includes:

- Increased opportunities for patients, carers and families to give feedback about their experiences by regular service user audits in both mental health and physical health, service users groups, weekly community patient forums, carers groups, PLACE audits, peer reviews, engagement and listening events
- Re-establishing the Families First group and developing its remit to support our work with carers and families (The Families First Group is made up of families, carers and friends of patients, experts by experience, and representatives of Trust staff. The Group works to improve the way that families, carers and friends are involved in incident investigations, and more broadly, in a relative's treatment and experience of care)
- Established a Trust-wide Working in Partnership Committee (this Committee has broad representation from patients, service users, carers, voluntary and community groups, and Trust staff)
- Co-produced an organisation plan for carers and their families
- Co-produced carers and families information booklets to be used in conjunction with Triangle of Care
- Established a patient and public involvement leads internal network to support staff with training, sharing good practice
- Increased our work with external partners (more information can be found on page 37)
- Implemented a number of Quality Improvement projects
- Recruited Experts by Experience, Peer Support workers and User Involvement Facilitators
- Continued to develop our approach to Triangle of Care in Adult Mental Health Services
- Established a carers drop-in service at Romsey Hospital with Hampshire Carers Together
- Established an engagement programme with young people which involves raising awareness of mental health, assessing current levels of support in schools and colleges, starting a Young People's Board

- In addition to the Triangle of Care training, completed five Carers Awareness training sessions for staff, delivered by Hampshire Carers Together
- Worked with the Princes Trust for Carers to increase service user involvement in the South East and currently developing a model for community support
- Implemented regular service user led audits across our mental health services
- Working with Healthwatch Hampshire to conduct regular service user led audits in our physical health services
- Reports to Board and Quality & Safety Committee
- Implementing patient stories and involving people in honest conversations when things go wrong.

We now work with a variety of stakeholders to support our engagement work and our commitment to working in partnership. Our partners bring valuable insight, expertise and act as critical friends.

Examples include:

Carers Together Hampshire	Working together to support delivery of the Joint Hampshire Strategy for Carers. Carers Together have delivered five carers awareness workshops for staff and have piloted an information and advice drop in service for carers and their families in Romsey Hospital which is now firmly established and will be rolled out to other sites.
Hampshire Cultural Trust	Joint work on an engagement project plotting a patient or carers experience of care through photography.
Healthwatch Hampshire	Regular participant in our Working in Partnership group. Healthwatch conducting service user/ patient audits in our physical health services.
Southampton Voluntary Services	Participants in our Quality Improvement workshops when appropriate e.g. volunteers, complaints.
Healthwatch Southampton	Participant in our Patient-Led Assessments of the Care Environment (PLACE) audits.
Princes Royal Trust for Carers	Supporting our application for accreditation for Triangle of Care. Supporting our work to improve access to community mental health services in the South East. Piloting a support service for patients/ carers.
Unloc (Student wellbeing social enterprise)	Facilitating our engagement work with young people in schools and colleges.
Touch Network (community interest company)	Story telling events have led to the sharing of patient stories with our board and advice on best practice for collecting patient stories. We are working on a proposal to work in partnership, holding events across Hampshire and encouraging Southern Health patients to share their experiences. Learning from peoples shared experiences and applying this to our services wherever possible
Time for Change (mental health voluntary organisation)	Joint working with young people. Provide training for young people.
External service user groups	Regular attendance to receive external feedback about our services, e.g. Community Engagement group, New Forest, Test Valley Locality group, Gosport Community forum, PPG's, Consult and Challenge, St Denys BME mental health users weekly forum.

Become the best employer:

What will success look like by 2024	Key actions we delivered in 2019/20
• A vacancy rate of **5%** • Reduced violence and harm towards staff by **50%** • A workforce that is representative of our local community at all levels • Top scores in the NHS Staff Survey • Leadership for mental health across the Hampshire and IOW system • Capacity and capability to deliver priorities.	• Implementation of a new structure to support devolved leadership and system working • Introducing competency based workforce plans with new roles and models of care that reduce vacancy rate • Improved staff engagement across the organisation: Top scores in the Staff Survey • Increasing employment for people with lived experience within the Trust • Refreshed People & Organisational Development Strategy.

A number of the elements of this section are covered later in the report (Section 2.3 page 97 onwards)

Implementation of a new structure to support devolved leadership and system working

A new way of organising and leading our services was introduced in April 2019 with the aims of greater local leadership and ownership (please see page 21 for more details); improved clinical leadership; local responsiveness; and far greater integration of services to enable more holistic outcomes for people. It was also anticipated that the delivery of this new approach would support decision making as close to the people using our services as possible enabling speedier decision making and improved quality.

Phase one introduced Clinical Directors leading teams of Divisional Directors of Operations, Nursing and Medicine. These quadrumvirates have now been in place for 12 months and, whilst still early in their journey have already made some significant contributions to improvements as detailed elsewhere in this report. Phase two saw the implementation of the rest of the leadership structures within the Divisions and was completed in September. Again these structures are early in their maturity but have contributed to our improving services.

As with many situations there is always learning to be made from the implementation of such a large scale change affecting many leaders/ managers. We have therefore undertaken a learning review to ascertain what went well and potential changes for the future which is just being finalised and the recommendations will be implemented next year.

Introducing competency based workforce plans with new roles and models of care that reduce vacancy rate

The Trust made good progress in reducing the vacancy rate and introducing a new workforce planning approach. In April 2019 as we entered the new financial year the vacancy rate was **9.9%** – by the end of the financial year it was down to **8.1%** with each of the last 6 months of the year showing a rate below **9%**.

At the end of 2018/19 the turnover rate for the year was just over **17%**; by the end of March 2020, the turnover for the year 2019/20 had reduced to **14%**, which is again good news.

Our new Clinical Divisions, supported by their Workforce Business Partners, have been developing workforce plans that support us to better serve our population. This process started once the new Divisions were in place in the Autumn and each division has an initial plan in place. The planning process starts with the understanding of needs and demands of our populations for the services we provide and the building a model/plan for the workforce based on the competencies required to deliver those service outcomes efficiently and effectively. Each Division has started this process with workshops during the year and our strategy sets out milestones to achieving this in the years ahead. We made good progress towards this over the last year which is a crucial first step; there is still further work planned and more to do to get them to the level that we want them to be.

There has been work to embed new roles such as Nursing Associate where our first cohort qualified during the year. There has also been the start of development of new roles to meet needs of the people using our services such as Apprenticeships in Occupational Therapy and nursing; Advanced Clinical Practice roll-out; introduction of Physicians Associates and Consultant Practitioners. These roles are linked to clinical need and demands and will be further enhanced as we gain further sophistication of our planning processes during 2020/21.

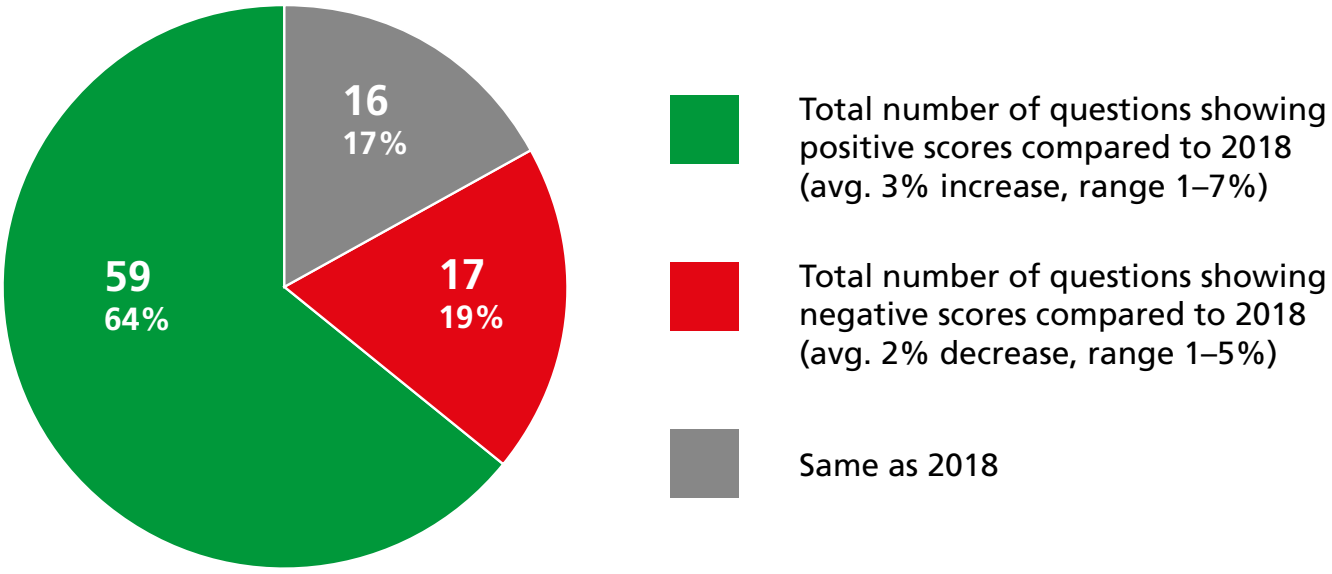
Improved staff engagement across the organisation: Top scores in the NHS Staff Survey

Staff engagement and satisfaction is one of the largest determinants of good patient outcomes. This year we have, through the People and Organisational Development Strategy and subsequent refresh, again had a major focus on culture and engagement. The Annual Staff Survey provides great feedback year on year and against peer organisations on the progress to becoming the Best Employer.

This year has shown continued improvement in our results and therefore the culture of the Trust both against previous years and against peers. The following charts detail our progress:

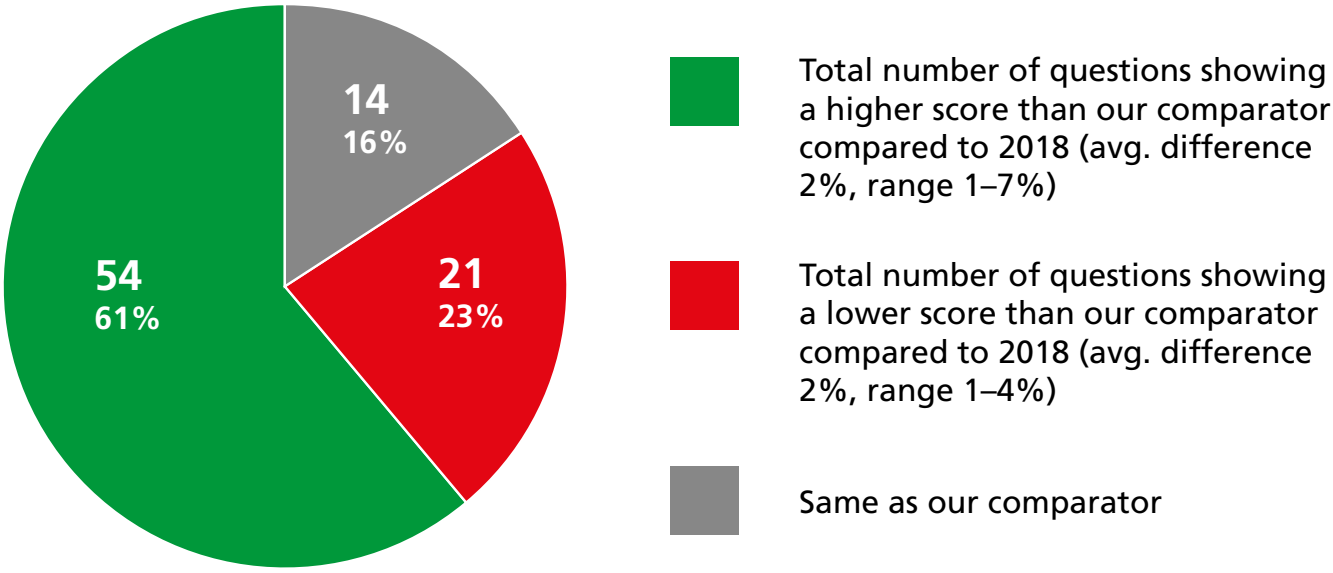
- Positive scores measured against 2018

Scale: Often. Always/ Agree. Strongly Agree/ Satisfied. Very Satisfied/ Yes Definitely. Yes to some extent.



- Positive score measured against comparator

Scale: Often. Always/ Agree. Strongly Agree/ Satisfied. Very Satisfied/ Yes Definitely. Yes to some extent.



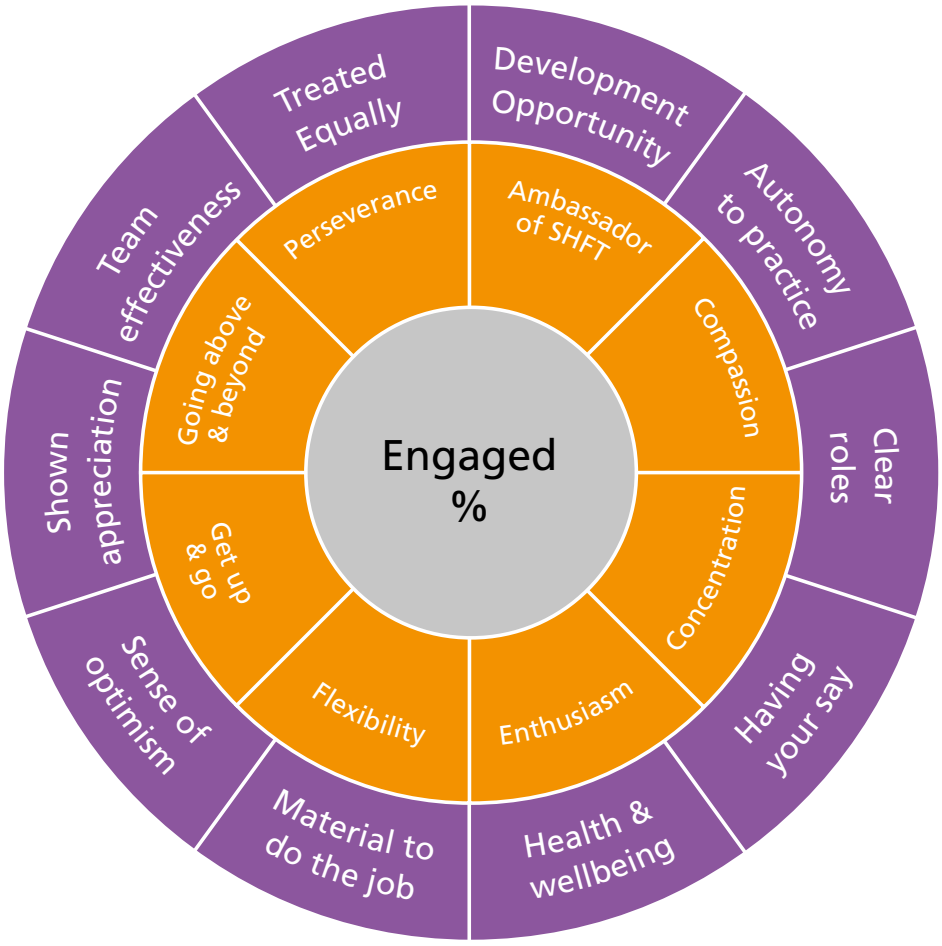
There is still significant work to do as a Trust to be the Best Employer however these continued improvements are encouraging.

Cultural Insights Tool

To build on the valuable data we have from the Staff Survey we have introduced a Cultural Insights Tool to the Trust during the year. This takes the best available evidence on engagement and produces a questionnaire (some questions of which appear in the Annual Staff Survey) and enables us to understand the culture within different teams. This enables us to support those teams that have the greatest need at any given time and also to share good practice from other teams.

The Culture Insight tool comprises 40 questions that measure both the 10 conditions that leaders can create to enhance culture (outside circle) and the eight behaviours that arise from working under the correct conditions (Middle Circle).

The Insight Tool is updated twice yearly, once as part of the national staff survey and once as an intermediate six monthly review initiated by the Trust. The results are populated on Tableau.



It is early days in reporting terms but there is encouraging signs that the tool is both helpful at team level and provides us with greater understanding of what it is like for our people in Southern Health.

The tool will continue to be used and deployed throughout 2020/21 as part of our refreshed strategy.

Increased employment for people with lived experience

This is an area that there has been some progress in during the year with a doubling of Peer Support Worker numbers from the previous year (now 21). However this falls far short of the ambition we have for Southern Health. In 2020/21 we will be introducing a step change in our Peer Support Worker numbers with the ambition that every Mental Health Team has at least one Peer Support Worker within 18 months. There is also a desire to explore similar roles within physical health services with a small number already in place within the Trust and to develop these further.

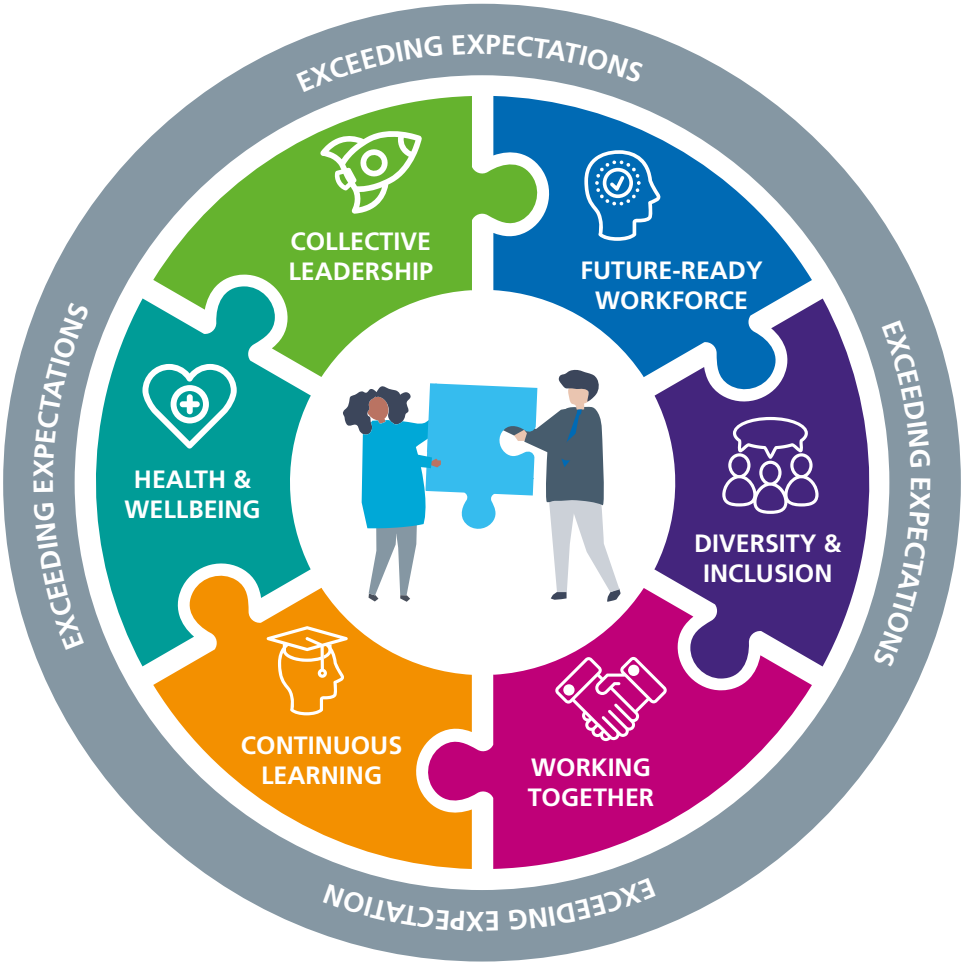
Providing a suitable environment for everyone to thrive in is a vital part of our aspiration for all who work for us. It is so important that we role-model the full range of opportunity for all within our communities and people with lived experience of using our services are especially important. Facilitating employment enables us to utilise that expertise and compassion in services, to help develop our culture to understand both provision and receipt of services to see our services as others see them, to harness the rich vein of talent, to break down the stigma associated with a number of our services and to role-model what can be achieved as an employer. We know that employment and occupation plays such a vital role in positive mental health when done well. Therefore we continue to set ourselves goals to improve opportunity within our People and Organisational Development Strategy.

Refreshed People & Organisational Development Strategy

In November 2019 the Board agreed a refreshed People and Organisational Development Strategy which further extends the ambition for the Trust building on the original strategy. This details four aims for delivery by 2024/25:

- Our NHS Staff Survey results in the top three nationally for comparator Trusts
- Vacancy level of **5%** or below
- Turnover less than **12.5%**
- Workforce is representative of our communities at every level

The delivery of the aims is demonstrated by the following diagram.



The Workforce & Organisational Development Committee has approved the work plan for the first year of the strategy with some ambitious aspirations for the coming year.

A **collective leadership** drawn from a **diverse and inclusive** local population will enable us to **work together** to generate a **future ready workforce** able to deliver world class care. Our staff will be retained through a great **health and wellbeing** offer, supported to fulfil their aspirations through **continuous learning**. All this progress will be delivered by the Workforce, Organisational Development and Communications Directorate by **exceeding the expectations** of our internal and external partners.

Transform services through integration and sustainable partnerships:

What will success look like by 2024	Key actions we delivered in 2019/20
• Innovative care for children and young people • Whole person, evidence-based care for the population we serve • Improved access for people in crisis.	• Redesign of Children's secure services pathway • Transforming our Children's services • Improved crisis care • A plan for needs-led integrated physical and mental health services • A plan for services based around primary care • Integrated intermediate care.

Redesign of Children's secure services pathways

Southern Health is aiming to provide a centre of excellence for Forensic Adolescent Care in the Southern region. This year we opened Austen House as a low secure forensic hospital for young people. This has allowed us to build the care pathway further and allow the seamless transfer of patients between levels of security and allow early intervention to stop young people needing medium secure facilities. This service also provides much needed additional beds within the UK for young people.

Transforming our Children's services

Southern Health is the provider of children and family 0–19 public health nursing services across Hampshire, delivering the national Healthy Child Programme supporting children to achieve optimum health and wellbeing from pre-birth to 19 years, including provision of the School-Aged Immunisation service and Child Health Information Service.

Over the past year we have transformed our 0–19 services in partnership with Barnardo's and been successful in securing the 0–19 contract for Hampshire enabling delivery of excellent service for Hampshire's children, young people and families for the next seven years.

Our innovative digital approaches such as the text messaging service, ChatHealth, for parents and for young people, and our "Visionable" video appointment options have improved access to our service and support when its needed enabling us to connect with children, young people and their families in the way they want us to.

Southern Health were successful in their bid for the School-Aged Immunisation Service making us the provider of important vaccination programmes to over **300,000** children and young people annually in Hampshire, and for the next seven years.

Underpinning these services is the Child Health Information Service (CHIS) which has demonstrated excellence in service delivery and the Trust has been selected to continue as the Hampshire CHIS service provider and take over provision of the service in Southampton, Portsmouth and the Isle of Wight.

Austen House: Meeting people's needs locally

In September 2019 we proudly opened Austen House, a low secure, forensic hospital that provides vital support for children and young people with specialist mental health needs. The 14 bedded hospital underwent a **£7m** refurbishment and supports some of the most vulnerable young people in society.

There is currently a national shortage of inpatient beds for children and young people needing specialist metal health care so the beds at Austen House will make a significant contribution to the availability of low secure care across the UK. As the only NHS unit of its kind in the South region, Austen House means young people and their families will not have to travel hundreds of miles to receive the vital support they need. Currently young people (and their families) have to travel as far as Manchester to receive care.

Austen House complements the existing medium secure unit, Bluebird House, which is on the same site at Tatchbury Mount. It will provide a much needed and valuable step-down care for patients and support them with rehabilitation so they can return to the community.

Improving crisis care

Working in partnership with Hampshire commissioners and the three Hampshire acute hospitals – University Hospitals Southampton NHS Foundation Trust (UHS), Portsmouth Hospitals NHS Trust (PHT) and Hampshire Hospitals NHS Foundation Trust (HHFT) – we successfully bid for national funds to increase psychiatric liaison (mental health in-reach) into Hampshire's four acute general hospitals.

A liaison mental health service already exists at Southampton General, Portsmouth's Queen Alexandra, Royal Hampshire County Hospital and Basingstoke North Hampshire Hospitals – but the new funding will allow the service to develop in a more coordinated way (to reduce variation across Hampshire) by having similar models and recruiting additional staff to expand the assessment and care offered to patients.

It will result in four psychiatric liaison teams, based on-site at each hospital operating 24 hours a day, seven days a week and aiming to see adults requiring mental health support within one hour of an emergency department referral.

In addition to the funding for improved psychiatric liaison services, we also worked with partners to secure a further **£1.1m** to invest in community-based crisis mental health services. The Trust linked with local commissioners across Southampton, Portsmouth and Hampshire, plus the Isle of Wight NHS Trust, Solent NHS Trust, and several local charities – Solent Mind, Havant Mind and Two Saints on the Isle of Wight.

The new money will see greater investment in peer support workers (people who have themselves experienced mental health problems) as well as nurses and medical staff in community teams. It will also enable more joined up services so that operating hours can be increased.

The Lighthouse

In March 2020 we relocated the Crisis lounge from Antelope House to a community base in Southampton City Centre.

The Lighthouse provides people in crisis with a safe, non-judgemental space to talk to mental health professionals and peer support workers.

People do not need to be using Southern Health services or have a referral to use the service. There is open access to support during opening hours.

The Haven

In January 2020 we launched a new pilot service to provide mental health support to adults in immediate need in the Havant and Waterlooville area. The project is a partnership between Havant and East Hants Mind, NHS South Eastern Hampshire and NHS Fareham and Gosport Clinical Commissioning Groups (CCGs) and Southern Health.

Service users are able to access support from Mind wellbeing practitioners, inclusion substance misuse staff and mental health clinicians from Southern Health.

A plan for needs-led integrated physical and mental health services

Work has commenced to develop programmes of transformation across all services. This work will include reviewing the interdependences between physical, mental health and learning disabilities to ensure services are person centred and personalised to the needs of an individual. This fits with the Hampshire and Isle of Wight Sustainability and Transformation Partnership (HIOW STP) national demonstrator site work programme for delivering personalised care and Southern Health is represented on the steering group.

This work will focus on utilising health behaviour change approaches and we have commenced this year with increasing the capacity to provide Making Every Contact Count (MECC) training to key group of staff including new starters and preceptees.

A plan for services based around primary care

GP practices are starting to work together in 'Primary Care Networks' (PCNs), to share their expertise and resources over wider geographical area. As part of the NHS's Long Term Plan, PCNs aim to integrate a lot of services which have traditionally worked separately – like mental health services, physiotherapy and social care.

Each PCN is developing teams of healthcare professionals, including GPs, pharmacists, district nurses, community paramedics, physiotherapists and other health workers, to provide tailored care for patients in their community.

Southern Health is engaged at all levels in the creation of the PCNs and the development of services. The emerging model of care is based around the needs of the local population and built around the natural communities.

There are many challenges to overcome as the models develop and our divisions have focussed on improving our services offered to the PCNs and building relationships with key parties including:

- attendance at each PCN locality meeting
- attendance at HIOW STP PCN Programme Board
- developing solutions together around a given population
- empowering the teams to work collaboratively
- understanding there is variation across the PCNs
- there are competing work programmes so it is essential to have a collaborative approach
- communicating effectively with staff and the public
- working together to meet workforce challenges.

We believe local, collective leadership and a 'one team' approach between primary and community services delivers the best outcomes for patients and makes the best use of finite resources.

We are keen to engage with PCN colleagues at a local level to develop a flexible package of support and explore new ways to work together. Our offer covers the full range of corporate functions, through to collaboration on designing and delivering new services and care pathways. Support and collaboration can be tailored to the needs of individual PCNs.

Integrated intermediate care

Integrated Intermediate Care (IIC) has been developed as part of the Hampshire Together programme of work. This sees health and social care providers working together to implement sustainable solutions for the effective flow of people from health services into onward social care, and to help people live with as much independence as possible. Service specifications have been developed and commissioned and a phased implementation will commence from 1 April 2020.

Intermediate Care is a multidisciplinary service, utilising rehabilitation, reablement and recovery focussed interventions for individuals at risk of hospital admission, or who have been in hospital to help them be as independent as possible. It is provided without charge to anyone aged 18 or over for up to six weeks and will see the integration of Hampshire County Council Reablement Services with Southern Health's rehabilitation services under single line management.

Such a large programme of change takes time to operationalise and deliver safely for the people who receive the service and also for the staff providing care. Over the last year we have been running a number of 'Forerunner' projects to test various aspects of the service as we work towards implementation.

Improve value:

What will success look like by 2024	Key actions we delivered in 2019/20
• No patients receiving care out of area • Efficient and effective use of resources and improved outcomes as a result • Reduced variation in practice and waste	• Reduced use of out of area placements • Development of the dementia pathway • Extending the psychosis pathway • Enhanced our perinatal mental health services • Our financial performance including cost improvements • Effective use of estate • Effective use of digital solutions

Reduced use of out of area placements

In July 2019 we took a new approach to tackling out of area placements. Sending patients miles away from their family and friends for treatment is a serious issue affecting many mental health providers across the country.

We introduced a 'Divisional Bed Management' system, (with a number of measures also introduced at the same time to support this). This meant that each of our four geographical areas/ divisions – Mid and North Hampshire, South West Hampshire, Portsmouth and South East Hampshire and Southampton – have more control over the beds in their area, rather than them being centrally managed by the Trust. By 'ring-fencing' their own beds, divisional teams are able to more efficiently manage the beds available.

By 'owning' the beds, each division is better placed to identify individuals likely to require admission earlier and be confident that if admission was required a bed would remain available (without other divisions filling it). By having this control over the acute resource, each division is in a position to manage the whole clinical pathway (community and acute inpatient), rather than the previous model where care is more fragmented.

At the end of July 2019, we had **64** people placed 'out of area' (with a further 16 contracted beds within Hampshire). Some 'out of area' patients had to travel hundreds of miles from home for appropriate care. By comparison, by the end of March 2020, the number of people being treated 'out of area' had decreased to **2** (with a further 25 contracted beds in Hampshire). So an overall reduction in non-Southern Health beds from **80** to **27**.

We believe that the raft of changes we introduced last summer are continuing to have a positive impact. The data shows a significant drop in the number of people now placed 'out of area' and a gradual decline in the distance from home that such placements are located. A direct result of being able to care for people closer to their own communities and support networks has meant that the length of time spent in inpatient care has reduced.

The Trust has also invested in a number of step down initiatives that has resulted, where possible, a patient's stay in hospital is not extended as a result of housing, support, or safeguarding issues. These initiatives have included the recruitment of a housing specialist, step down beds, closer working with the local authority, and investment into the crisis pathway.

Development of the dementia pathway

In the development of a Dementia pathway which has a shared a vision for every person who uses services, and their carers and families, to receive high quality, compassionate care along the pathways from pre-diagnosis through to end of life care. This will apply to all care settings, whether home, hospital or care home. There will be a whole system approach to develop NICE compliant pathways which are responsive and collaborative in the delivery of services. The transformation of services for older people will need to take account of the growth in the local population of people aged **65** and the very high proportion of older people who live locally. For example **30%** of the population of Lymington is over 75. The number of people living with dementia in our area is higher than the national average and is predicted to increase, indicating a potential rise in demand for dementia health services. Estimates show that in Hampshire and Isle of Wight only **65%** of people with dementia have a diagnosis with the present NHS England target requiring **66.7%** of people estimated to have dementia to have a recorded diagnosis in their GP records. In order to meet this national target we plan to develop new posts such as an advanced Nurse Practioner to deliver the national target of diagnosis of dementia from referral to diagnosis in six weeks. The post will be implemented in Basingstoke by summer 2020.

Work is also underway to look at the development of a care home in reach team as part of a dementia crisis service to manage complex and challenging behaviour in a person with dementia, in the Basingstoke area. The South East Community Mental Health Team (CMHT) for older persons took part in a pilot project around managing complex behaviours in people with dementia, either in their own home or a care home from November 2019 till Feb 2020. The pilot was able to prevent a number of admissions to either an acute hospital or a mental health bed. The service plans to develop local dementia crisis teams as part of the CMHT's to manage complex and challenging behaviour. These teams will in reach to care homes and a person's own home to avoid unnecessary admission to either an acute hospital or a mental health acute bed. It will also, as part of its function, enable early discharge either to a care home or a person's own home by providing crisis intervention to manage complex and challenging behaviours.

Extending the psychosis pathway

In 2019/20 we agreed the investment for Hampshire to allow us to extend the service to the full age range of 14–65yrs and for it to be compliant with NICE levels.

Our teams have extended the acceptance criteria for those patients over 35 years (up to 65) who present with a first episode of psychosis. In 2019/20 the service has seen an increase in demand by around **25%** due to the change in age range.

Enhanced our perinatal mental health services

Investment has enabled a structured and subsequent mobilisation plan being agreed between Southern Health, NHS England (NHSE) and the Clinical Commissioning Groups to provide equitable and timely access to high quality specialist perinatal mental health community services, throughout Hampshire. It has enabled the delivery of a rapid response service which gives access to urgent face to face intervention from a specialist perinatal team (previously they would have been referred to the Community Mental Health Team or admitted to a Mother and Baby Unit). As practitioner capacity has been increased through investment in specialist roles and an increase in nursing, the service able to manage the increased growth and continue to meet the national standards; assessment and waiting times and pre-conceptual counselling. Referrals for psychology assessments and treatment continue to be met within four weeks of referrals as the investment in psychology has enabled demand to be met. In addition the service continues to offer a wide range of nationally recognised interventions such as the Perinatal Emotional Coping Skills Group. Preventative work around education and supervision within the wider perianal pathway is also delivered.

Financial performance

The Trust began the year facing a significant financial challenge; a planned control total deficit of **£6.2m** which required national support of Financial Recovery Funds (FRF) and Provider Sustainability Funds (PSF) of **£6.2m** to achieve break even; awarded upon the successful delivery of the control total on a quarterly basis. It became clear by the end of quarter three that we were not going to be able to achieve the control total during the final quarter. We approved a reforecast in January which anticipated a deficit of **£9.5m** which acknowledged we would not be successful in being awarded the quarter four PSF/ FRF of **£2.2m**.

In terms of our in year financial performance, our final control total deficit was **£5.7m** which included receipt of FRF / PSF of **£4.2m**. Although the final position did not achieve break even, it was a significant improvement against the reforecast position approved in January.

The main financial and quality challenge which contributed to this included our continued use of out of area placements for mental health patients with final spend for the year totalling **£14.4m**. Although this was much higher than the plan of **£7.4m** it was reducing significantly towards the end of the year based on actions described on page 47. During the year we have worked with our Commissioners to demonstrate that our bed base for mental health is significantly lower than national benchmarks for the size of our population. They have agreed an investment strategy to support the Trust on creating additional wards within the Trust to reduce the financial and quality issues linked to the use of out of area placements.

In line with previous years we were unable to identity and deliver fully recurrent cost improvement plans and within the total delivered of **£13.2m**, **£7.4m** was achieved non recurrently. During 2020/21 these savings need to be identified recurrently to ensure we are financially sustainable in the medium term. The savings delivered in 2019/20 included service and workforce redesign, procurement and reduction of corporate overheads. All savings are reviewed for the impact on quality, safety and patient experience.

The above paragraphs focus on the Trusts' position against control total which is how we are measured by NHS Improvement. There are some differences between this approach and the way that the accounts are presented to conform with accounting standards. The main difference is the inclusion of impairment and revaluation losses in our financial statements. These are technical adjustments which do not result in actual cash being paid out but ensure that our assets and reserves are carried out at the right value.

The Trust is reporting income of **£337.3m** and operating costs of **£335.1m** resulting in an operating profit of **£2.3m** compared to **£3.9m** operating deficit in 2018/19. Once non-operating costs (financing costs) have been considered the position is a deficit of **£3.4m**. The difference between this and the control total deficit of **£5.7m** relates to the accounting of impairment costs and depreciation on donated assets.

The cash balance decreased from **£20.4m** to **£13.3m** at 31 March 2020. This reduction was principally as a result of the deficit position and capital expenditure being planned for at a higher level than the depreciation charge. Following the reforecast position in January it became clear that there was a risk to our overall cash balance and that it may drop to a level lower than allowed by NHS Improvement. The Board approved an application for revenue support from the Secretary of State of **£5m** which comes in the form of a loan. This was agreed and was received during March. Based on the revised financial arrangements for 2020/21 this loan will not now need to be repaid.

The Trust invested **£18.8m** in a range of capital projects. These include the following:

- investment to improve safety and patient experience such as door sensors to reduce harm from fixed ligature points, high dependency area with dedicated sensory
- investments in technology to enhance the digital offering to our clinicians
- planned maintenance to ensure safe services with improved patient experience in our buildings, for example refurbishment of wards, bedrooms and bathrooms
- replacement of medical devices which included a new CT Scanner for Lymington Hospital paid for by the Lymington League of Friends and a legacy donation received by the Trust
- transformation projects such as the Secure Services developments on site at Tatchbury for both Child and Adolescent Mental Health Services (Austen House, completed Summer 2019) and Learning Disabilities (Ashford, planned completion of early Autumn 2020)

We ended the year with an NHS Improvement Use of Resources rating of an overall 3 (out of 4, where 1 is low risk and 4 is high risk) and is consistent with last year's rating. This rating reflects the level of the outturn deficit, variation to the planned break even and the increase in agency costs.

We had made good progress in 2018/19 on reducing our agency costs and they were down to **4%** of total pay costs. This increased to **5.7%** in 2019/20 linked mainly to medical locums (medical locums spend being **21%** of the total medical paybill compared to **13%** in 2018/19) and our difficulty in recruiting to these posts as well as our ambition to strengthen clinical leadership within the Trust.

Financial Outlook

Prior to the Covid-19 pandemic the NHS organisations across Hampshire were working together to deliver a financially compliant plan for 2020/21. It was anticipated this would be a challenging year ahead with significant transformation required to deliver the service improvements as well as a reduction to the overall cost base within Hampshire. At the draft planning stage, prior to Covid-19, the Trust was expecting to have a deficit of **£11.4m** which would be supported by a Financial Recovery Fund of **£11.4m** to deliver a breakeven position.

In mid March the financial arrangements for 2020/21 were changed to ensure maximum support was given to the pandemic. The overall approach was to reduce burden, increase cash flexibility and give confidence about the short term financial position but within an environment that still required strong financial control. This included pausing the operating plan, replacing the contract negotiations between commissioners and providers with a nationally calculated block and top up arrangement as well as the commitment that legitimate additional costs incurred as a result of responding to Covid-19 would be covered. These arrangements were initially put in place until July and have more recently been extended to October. The national intention is that Trusts will be given support to breakeven during this challenging time. Given the uncertainty about the arrangements for this year the Trust has considered the technical issue of going concern and has declared that there are material uncertainties. This is covered in more detail in page 23.

Effective use of estate

The draft Estates Strategy sets out the principles of how the Estate will be managed into the future, with a focus on rationalisation aligned to the clinical strategies. An Estates optimisation project initiation document (PID) has been developed to support this strategy. It outlines the objectives of reducing the Trusts Estates portfolio by **30%** by 2023 and increasing the utilisation of the Trust's Estate by **70%** by 2023 (Department of Health (DoH) set target). The PID outlines the management structure and governance arrangements for the delivery of the optimisation programme.

Progress to date against these objectives is as follows:

- Introduction of an accommodation and space management policy which supports the Trust's approach to the development of maintenance and effective utilisation of the physical estate. It also supports the environmental aims the Trust has set in maintaining and utilising the physical estate in support of improving quality and efficiencies
- Following an option appraisal of the outsourced cleaning service; it was ascertained that from January 2020. The contract should be extended
- A five year capital programme has been further developed in-line with transformation and rationalisation plans
- Realigned operational estate services teams to improve efficiency and performance outcomes. This was achieved through the development of Operational Management roles across hard and soft facilities management focused on accountability at service delivery
- Following the successful opening of Austen House our refurbished and repurposed child and adolescent mental health unit, Southern Health was invited to attend the 'HSJ Transforming Mental Health Summit' in Leeds in November last year. The 'Austen House Project' was presented and an explanation was delivered of how the design was developed and how service users were included all the way through the design process, and how service user inclusion had influenced the end product. The presentation was very well received, and given the amount of interest post the presentation, a number of other Trusts are interested in our approach to service user inclusion.

Progress has been temporarily affected by the response needed to support rapid infrastructure changes due to Covid-19. This included meeting the extra bed capacity needed which equated to circa **340** additional beds. Whole system wide working was required and one example was Woodcot Nursing Home which required this collaborative approach. It was an exceptionally well-executed project that turned a 3 storey building that had been empty for 2.5 years into an **83** bed provision in just over **3** weeks; a great example of the system working together with a common goal, breaking down barriers and delivering extra capacity for our patients. Our Estate teams who were already working under immense pressure really shone as a team and collectively continually worked over and above to ensure the delivery of each ward.

The new Ashford Learning Disabilities Residential Unit currently being built on the Tatchbury Mount site is a low secure building to cater for **10** adult male inpatients. The new building is tailored around the needs of the patients with all the up to date facilities needed to enable the Trust to continue providing the best care to our patients. Our patients, families and carers and our staff have had an opportunity to influence the interior design of the residential building. Despite delays incurred due to Covid-19 the building is due to be completed and opened and occupied by autumn 2020.

Effective use of digital solutions:

The use of digital solutions is an integral tool to improving the care that we provide to patients, and ensuring the safety of the information that we hold is key to enabling us to do this. The Trust's security and networks teams have continued to make sure that the Trust complies with Cyber Essentials Plus Government accreditation ensuring that the Trust's approach to Digital Solutions and cyber security measures meet government certification; ensuring a safe and secure digital environment for patients and staff.

The Trust has continued to remain compliant with the Department of Health and Social Care's mandated Data Security and Protection Toolkit, demonstrating our continued commitment towards data security and education of staff on the safe handling of electronic data, thereby providing assurance of our compliance with National Guidelines against the mandated 10 data security requirements.

Wherever possible, integration and collaborative working takes place with neighbouring healthcare organisations across Hampshire and the Isle of Wight via the Sustainability and Transformation Partnership (HIOW STP), exploring opportunities for collaborative work and ensuring greater integration of software and systems wherever possible.

Routine work within the Trust has continued in terms of refreshing hardware across the Trust, migrating devices from Windows 7 to Windows 10 and guaranteeing that the Trust is operating the most up to date, supported software. Once the bedrock of supported, safe and secure hardware is in place, the Technology Team can build upon this foundation to implement programmes and roll out digital solutions and initiatives in line with the Trust's Strategy of enabling a Digital Clinician. Consultation around this work continues within the organisation and the opportunity to exploit external support around dynamic scheduling of appointments, mobile technology, clinical apps and electronic observations systems have been backed up through prospective bids from external sources. As an enabler to the organisation's efficiency, this work has formed a core part of the medium term digital transformational schemes.

The key initiatives surrounding the Digital Clinician transformation programme have been:

- **Video appointments** – allowing greater patient access choices for Trust services via video appointments, take up of this service has been significant with around **300** appointments taking place daily throughout the Trust across the whole spectrum of services
- **RiO Mobile** – allowing clinicians safe and secure access to a tablet/ smartphone instance of RiO rather than standard laptop access; this allows records to be taken by clinicians with greater ease and efficiency savings of up to **50%** in terms of time taken to complete records
- **Mobile working** – allowing secure, innovative access for personnel to work remotely and flexibly away from Trust sites; initiatives such as utilising staff's own hardware, providing increased numbers of mobile working devices and laptops and facilitating secure remote access for staff needing to work in more flexible ways.

Social, community, anti-bribery and human rights issues

The Trust has a responsibility to provide healthcare to the community that it serves.

This year we have had representation at various public events, reaching out to thousands of people from different walks of life. Stands/ Information in regards to our services have been provided at the annual BAME (Black, Asian and Minority Ethnic) cultural festival, African Caribbean event, PRIDE LGBT+ festival, Basingstoke Disability Awareness Day, University events and Hampshire Hate Crime meeting with fantastic response. We have had members of different groups, such as Southampton Council of Faiths, Hampshire Constabulary, Romsey Disability Network and Chrysalis attend our staff events, with members of our Trust board present. We also have representation from Southern Health at various Network meetings, such as Hampshire Hate Crime and Romsey Disability network. We held a dedicated Board focus session on diversity and inclusion.

As an employer that focuses on equality, diversity and inclusion, and with an integrated society, the Trust promote diversity and inclusion and has a statutory responsibility to give due regard to the Equality Act 2010 and the Human Rights Act 1998 as a minimum standard.

Southern Health is committed to creating a culture where equality, diversity and human rights are promoted actively and discrimination on the basis of peoples protected characteristics is not tolerated.

The Trust Board is committed to:

- ensuring that the organisation has equality, diversity and inclusion objectives that meet the requirement of the Public Sector Equality Duty as set out under the Equality Act 2010
- receiving and considering regular reports in order to evaluate the effectiveness of the policy
- review of the Diversity scorecard that is released annually
- the Equality Delivery System 2
- the Workforce Race Equality Standard
- the Workforce Disability Equality Standard.

In January, the Trust made reducing bullying and harassment a priority project in response to the latest Staff Survey findings which had shown an improvement from the previous year (but not by the levels we wish to see), although it also showed a deterioration in reporting. This highlights the Trust's Zero tolerance to any forms of discrimination.

We have a number of policies in place which cover social, community and human rights matters, such as the Equality, Diversity and Human Rights Policy. Policies are monitored for effectiveness and to ensure they are embedded across the organisation. Equality Impact Assessments are regularly undertaken to ensure our policies are inclusive.

The Trust has recently refreshed the People and Organisational Development Strategy, which continues to include key objectives and milestone measures to ensure that all staff are treated fairly as one of the six primary themes of the strategy.

Anti-bribery issues

The Bribery Act 2010 places specific responsibility on organisations to have in place sufficient and adequate procedures to prevent bribery and corruption taking place. The Trust has a dedicated counter fraud resource, an Anti-Fraud, Bribery and Corruption policy, and a strategic approach to counter the risks of fraud and bribery. We have adopted a zero tolerance policy to fraud, corruption, bribery, money laundering or any similar act within the NHS.

Environmental matters

As a Foundation Trust, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve and planet we inhabit. Sustainability means spending public money well, the protection and efficient use of natural resources and building healthy, resilient communities. By considering the social, environmental and economic impacts of our Trust services we can improve health both in the immediate and long term, even in the context of rising cost, the climate emergency and detrimental impacts on our planet's finite natural resources. This requires a clear focus on reducing emissions that contribute to climate change and poor local air quality, minimising waste, making the best use of scarce resources and being resilient to the effects of a changing climate.

The Trust supports the NHS England and NHS Improvement 'For a Greener NHS' initiative, recognising that delivering the goal of 'net zero' emissions will require a consistent focus. Demonstrating that we consider social and environmental impacts also ensures that the legal requirements in the Public Services (Social Value) Act (2012) and the Climate Change Act (2008) are met.

In the calendar year ending December 2018, we had an estimated total carbon footprint of **60,387** tonnes of carbon dioxide equivalent emissions (tCO_2e), which is a decrease of **20%** from our 2013 baseline. We have increased our Sustainable Development Assessment Tool score to **71%** and have successfully managed to reduce our energy, travel, procurement and waste carbon footprint from last year. Whilst we have made good progress in reducing our overall environmental impact in 2019 we recognise that more needs to be done to support the UK's essential transition to a low carbon economy, and achieve our strategic goal to reduce our carbon emissions by **28%** by 2020, using 2013 as the baseline year.

For a more detailed update, please see our full Sustainability Report from page 140.

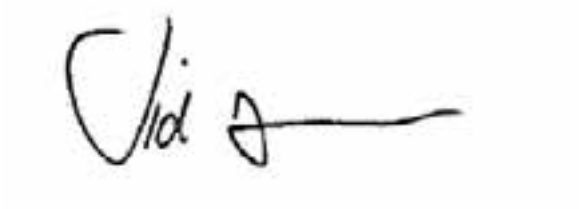
Post year-end events

References to post year end events can be found in the accounts (section 3) in note 34.

Overseas operations

The Trust is not currently pursuing any business activities outside of the UK.

Signed:



Dr Nick Broughton, Chief Executive

2 June 2020

2. THE ACCOUNTABILITY REPORT

2.1 DIRECTORS' REPORT

Our Trust Board

As of 31 March 2020 our Board is made up of the Chair and seven Non-Executive Directors, the Chief Executive and six Executive Directors.

The Trust Board is responsible for the leadership, management and governance of the organisation and setting our strategic direction. They also have a role in ensuring high standards are maintained. Together they bring a wide range of skills and experience to the Trust. The Board is legally accountable for the services the Trust provides and ensuring it operates to the highest of corporate governance standards.

Board composition

In 2018/19 we reviewed the composition of the Board to ensure there was the appropriate balance of knowledge, skills and experience. This resulted in a number of key appointments being made to the Board in 2019/20.

Executive Directors		
Name/ title	**Committee responsibilities**	**Biography**
Dr Nick Broughton Chief Executive	Attended 11/11 Board meetings he was eligible to attend during 2019/20 Member of: • Finance & Performance Committee • Quality & Safety Committee • Executive Management Committee • Transformation Steering Committee Attendee of: • Audit, Risk & Assurance Committee • Nominations & Remuneration Committee	Nick was previously Chief Executive at Somerset Partnership NHS Foundation Trust. Nick is a psychiatrist by background and has worked as a Consultant in Forensic Psychiatry since 2000. He graduated from Cambridge University in 1989 and completed his medical training at St. Thomas' Hospital Medical School. He trained in psychiatry in North West London. During the course of his consultant career he has worked in a wide variety of secure settings including a specialist remand service, an enhanced medium secure service for women, a remand prison and a young offenders' institution. Nick held a number of managerial positions prior to joining the Trust including a Clinical Director for a forensic service and Medical Director of a large specialist mental health Trust. In January 2012 he was appointed Chair of the National Clinical Reference Group for Secure and Forensic Mental Health Services, a position he held until 2014. He was joint Clinical Director and Co-Chair of London's Strategic Clinical Network for Mental Health and a Director of Imperial College Health Partners.

Name/ title	Committee responsibilities	Biography
Paula Anderson Finance Director	Attended 8/11 Board meetings she was eligible to attend during 2019/20. Member of: • Charitable Funds Committee • Finance & Performance Committee • Workforce & Organisational Development Committee • Executive Management Committee Attendee of: • Audit, Risk & Assurance Committee • Quality & Safety Committee	Paula joined the Trust in 2009, and was appointed as Deputy Director of Finance in 2014. Prior to this, Paula's finance experience was within commissioning, including the Finance Director for Mid-Hampshire PCT between 2001 and 2006. As part of her role at Southern Health, Paula leads on finance, procurement and contracting; she also held the Executive lead for Estates and IM&T, until the appointment of Heather Mitchell. During 2019/20, Paula also provided cover for the Chief Operating Officer role from July until early November.
Paula Hull Director of Nursing and Allied Health Professionals	Attended 9/11 Board meetings she was eligible to attend during 2019/20. Member of: • Charitable Funds Committee • Finance & Performance Committee • Mental Health Legislation Sub-Committee • Quality & Safety Committee • Workforce & Organisational Development Committee • Executive Management Committee • Transformation Steering Committee Attendee of: • Audit, Risk & Assurance Committee	Paula qualified as a registered nurse at Southampton Hospital in 1988. Following a long career in community nursing, she became a practice nurse, working in primary care for over 10 years. After several years as a Matron in Primary Care, she joined Southern Health. She also worked at South Central Strategic Health Authority as a Patient Safety Manager. She attained a Masters in Leadership and Management from the University of Southampton in 2013 and became the Associate Director of Nursing and Allied Health Professionals in the Integrated Services Division in 2014. This included responsibility for all Nurses and Allied Health Professionals and accountability for ensuring patients, service users and families are at the heart of our services.

Name/ title	Committee responsibilities	Biography
Paul Draycott Director of Workforce, Organisational Development and Communications	Attended 11/11 Board meetings he was eligible to attend during 2019/20. Member of: • Finance & Performance Committee • Executive Management Committee • Transformation Steering Committee • Workforce & Organisational Development Committee Attendee of: • Nominations & Remuneration Committee	A former general nurse, Paul has first-hand experience of working and supporting front line NHS services. Paul joined the NHS in 1985. Amongst others he has held previous Board-level posts, including Director of Leadership and Workforce at North Staffordshire Combined Healthcare NHS Trust; Director of Organisational Development and Workforce at both Shropshire County Primary Care Trust and Shropshire Community Healthcare NHS Trust. He was also Director of Human Resources and Organisational Development at South Staffordshire and Shropshire Healthcare NHS Foundation Trust. From 14 May 2019, Paul became a full voting member of the Board.
Dr Karl Marlowe Chief Medical Officer	Attended 11/11 Board meetings he was eligible to attend during 2019/20. Member of: • Finance & Performance Committee • Executive Management Committee • Transformation Steering Committee • Workforce & Organisational Development Committee • Quality & Safety Committee • Mental Health Legislation Sub-Committee	Karl trained at Liverpool Medical School, Barts and The Royal London, Maudsley Hospital and Guys and St Thomas Hospitals, with postgraduate qualifications from UCL and the Institute of Psychiatry, as well as the Said Business School at Oxford University. He was Clinical Director of Adult Mental Health at East London NHS Foundation Trust. He is also Group Chair of the Social Interest Group (a not-for-profit organisation set up to enrich and extend opportunities for people facing social and health challenges). Karl recently worked as liaison psychiatrist for renal medicine at Royal London Hospital. Karl has lectured at Queen Mary, University of London (medical school) and City University of London (nursing school). Dr Marlowe was born and raised in the Caribbean, and has worked in Bermuda and New Zealand as well as the UK.

Name/ title	Committee responsibilities	Biography
Heather Mitchell Director of Strategy and Infrastructure Transformation From 05 August 2019	Attended 7/7 Board meetings she was eligible to attend during 2019/20. Member of: • Executive Management Committee Attendee of: • Finance & Performance Committee Attendee of: • Audit, Risk & Assurance Committee	Prior to joining the Trust, Heather was Director of Strategy and Partnerships for West Hampshire Clinical Commissioning Group (CCG), where she held the responsibility for CCG strategy and business planning, mental health commissioning across Hampshire, children's commissioning for West Hants CCG, digital transformation and governance. She previously worked with Hounslow and Richmond Community Healthcare (HRCH) NHS Trust, where she was the Director of Planning and Performance. Heather holds a Master's Degree and PhD in Civil Engineering and prior to joining the NHS she worked in engineering consultancy and project management.
Grant MacDonald Chief Operating Officer From 04 November 2019	Attended 6/6 Board meetings he was eligible to attend during 2019/20. Member of: • Finance & Performance Committee • Executive Management Committee	Grant joined the Trust in November 2019, he came from Central and North West London NHS Foundation Trust, where he was Executive Director of Strategy and Workforce. Grant joined the NHS in 1988 and has a broad range of experience across Acute, Community and Mental Health providers. He qualified as a nurse in 1991 and over the last 16 years has held a number of Trust Board roles including Chief Operating Officer, Director of Nursing, Deputy Chief Executive and Acting Chief Executive.
Barry Day Chief Operating Officer 9 July 2018 – 12 July 2019	Attended 3/3 Board meetings he was eligible to attend during 2019/20. Member of: • Charitable Funds Committee • Finance & Performance Committee • Mental Health Legislation Sub-Committee • Quality & Safety Committee • Executive Management Committee • Transformation Steering Committee • Workforce & Organisational Development Committee	Barry is an experienced Chief Operating Officer who has worked in both NHS and local authority settings. In his role, Barry is focused on supporting and enabling front line staff to deliver the best possible patient care, ensuring the Trust is integrating mental and physical health care most effectively to serve local communities. A former social worker, Barry has operated at senior and executive level within a range of NHS Trusts including in Coventry, Leicester, London and Berkshire. Barry has previously served in the RAF and as an outdoor pursuits instructor. He is also a qualified and experienced coach and mentor.

Non-Executive Directors		
Name/ title	**Committee responsibilities**	**Biography**
Lynne Hunt Chair	Attended 10/11 Board meetings she was eligible to attend during 2019/20. Member of: • Nominations & Remuneration Committee (Chair)	Lynne has a track record of over 40 years public service, working in the NHS within mental health and learning disabilities services. She began her career as a nurse in Dorset, before moving to London and has held a number of clinical and Board level roles. Most recently she was Non-Executive Director and Vice Chair of Dorset HealthCare University NHS Foundation Trust.
Jeni Bremner Non-Executive Director, Deputy-Chair	Attended 9/11 Board meetings she was eligible to attend during 2019/20. Member of: • Audit, Risk & Assurance Committee • Finance & Performance Committee (Chair) • Mental Health Legislation Sub-Committee • Nominations & Remuneration Committee • Quality & Safety Committee • Workforce & Organisational Development Committee (Chair until November 2019)	Jeni has worked in public service for over 25 years in the NHS and Local Government. A nurse by background, Jeni is also a health economist and worked as a Policy Analyst at City Health Trust in Newcastle. She then moved to join the Local Government Association (LGA) as a Programme Manager progressing to the LGA Board as a Programme Director. In 2007, she became Chief Executive of an international health charity, the European Health Management Association, focusing on policy and practice to improve health management. Since leaving in 2016, she has provided change management consultancy services and cared for her Step Father who has Alzheimer's. She has held various Trustee roles since the 1990s and is currently a Trustee for a local care home.

Name/ title	Committee responsibilities	Biography
David Kelham Non-Executive Director	Attended 10/11 Board meetings he was eligible to attend during 2019/20. Member of: • Audit, Risk & Assurance Committee (Chair) • Charitable Funds Committee (Chair) • Finance & Performance Committee • Nominations & Remuneration Committee • Workforce & Organisational Development Committee	David is a Fellow of the Institute of Chartered Accountants in England and Wales and held Chief Financial Officer (CFO) roles in major UK based companies for 24 of his 34 year executive career covering 48 different countries. In 2010 he was nominated by one of the leading accounting firms as 'an outstanding international CFO'. David was a member of the Scout Association for 40 years, rising to Explorer Scout Commissioner before retiring. He is also a past member and Chairman in the Round Table organisation, and a member and past Chairman of the Ex-Round Tabler's Association. His mother lived with Alzheimer's for 10 years before her death in 2011.
Robert Goldsmith Non-Executive Director	Attended 9/11 Board meetings he was eligible to attend during 2019/20. Member of: • Finance & Performance Committee • Nominations & Remuneration Committee • Quality & Safety Committee • Workforce & Organisational Development Committee (Chair from November 2019) Attendee of: • Audit, Risk & Assurance Committee	Robert has held a series of senior executive roles in the aviation and other transport-related industries, including a leading airports group with multi-billion pound assets. He brings with him a wealth of experience in strategy, commercial and operational business, and many relevant transferable skills to a healthcare setting. Examples include expertise in dealing with a diverse range of stakeholders and community groups, safety management systems, cultural change, project management and delivery of customer experience improvements. Robert has previous Non-Executive Director experience on the Board for The Islands' Tourism and Business Partnership (Visit Isles of Scilly) and for Hull and Humber Chamber of Commerce, as well as a number of other Executive Board-level roles.

Name/ title	Committee responsibilities	Biography
David Monk Non-Executive Director, Senior Independent Director	Attended 9/11 Board meetings he was eligible to attend during 2019/20. Member of: • Charitable Funds Committee • Mental Health Legislation Sub-Committee (Chair) • Nominations & Remuneration Committee • Quality & Safety Committee	David is a Director and co-founder of Symmetric, an organisation specialising in Systems Thinking and System Dynamics Modelling across the public sector. He continues to be a significant contributor to mental health networks in England and has co-authored a number of papers on Care Pathways and Mental Health Strategy. With 30 years' experience either in or alongside the NHS, David has a track record of partnership working including experience of involving patients and the public in major planning decisions, particularly where this has led to a major reorientation of capacity and demand. His ongoing portfolio includes the continued facilitation of a number of Mental Health CEO and Medical Director networks across different regions in England. David also continues to Chair the Lambeth Living Well Collaborative; a focus on better care through collaboration. He previously led the award winning London Early Intervention in Psychosis programme and is now an advisor to the South London Partnership, focussing on mental health improvement and the new models of care approach.
David Hicks Non–Executive Director	Attended 9/11 Board meetings he was eligible to attend during 2019/20. Member of: • Audit, Risk & Assurance Committee • Finance & Performance Committee • Nominations & Remuneration Committee • Quality & Safety Committee (Chair) • Transformation Steering Committee	David has over 30 years' experience in clinical leadership posts. Most recently he has been interim Medical Director at Great Ormond Street, where he was the Trust lead for patient and staff safety and clinical quality, responsible for the legal team, medical workforce, education and development. After qualifying as a Consultant, David specialised in sexual health and genitourinary medicine before progressing into divisional management roles. He has held a range of Board Level clinical leadership posts in the course of his career, as well as being Acting Chief Executive at Barnsley Hospital from 2006 to 2007. David held a number of roles with Mid Yorkshire Hospitals NHS Trust, advising on the Trust's clinical reorganisation and Chairing the Quality Committee, leading on safeguarding and End-of-Life Care. In addition to his role at Great Ormond Street, he was also a Clinical and Professional Advisor to the CQC and a Medical Appraiser to NHS England, supporting a number of GPs across the South of England. He is also an Honorary Senior Lecturer at the University of Sheffield and an Assistant Professor at the University of St. Matthew's in Miami.

Name/ title	Committee responsibilities	Biography
Kate FitzGerald Non–Executive Director From 14 May 2019	Attended 8/10 Board meetings she was eligible to attend during 2019/20. Member of: • Nominations & Remuneration Committee	Kate's main career was as a senior lawyer in a globally significant, highly regulated financial institution and included working with regulators and industry working groups. Kate used this time to gain experience and understanding of the dynamics and challenges that individuals and complex organisations face including how to work through them. Kate is currently a school Governor and a Special Education Needs lead Governor. She also has personal experience of dealing with disability and terminal conditions as well as the profound effects of this for carers and families in the short and long term.
Michael Bernard Non–Executive Director From 14 May 2019	Attended 10/10 Board meetings he was eligible to attend during 2019/20. Member of: • Nominations & Remuneration Committee	Michael's career has been in IT, with spells in Sales and Marketing leadership, culminating in a role as an International Marketing Director. He is on the Boards of two well-established charities, is a Governor at a Secondary School and sits on the Advisory Board for Exeter University Business School. Exposure to mental health problems close to him has given him a long-standing interest in this area and motivated him to apply to the Trust. He hopes to be able to help the Trust with his experience in leadership in a large, complex organisation, as well as a background in strategy and communications.

Register of interests

The Chair, Executive Directors, Non-Executive Directors and Governors have declared any business interests that they have.

The Trust Chair and all Non-Executive Directors meet the independence criteria laid down in NHS Improvement's Code of Governance (provision A.3.1) and we are satisfied that no direct conflicts of interest exist for any member of the Board. Information is made available to the Council of Governors when considering matters relating to appointments.

These declarations are held on our website at:

- for Board: https://www.southernhealth.nhs.uk/about/trust-board/meetings/
- for Governors: https://www.southernhealth.nhs.uk/about/council-of-governors/meet-our-governors/

Board effectiveness and evaluation

All Board members undergo annual performance appraisals. The Chair undertakes the process for the Non-Executive Directors and the Chief Executive. The Chair is in turn appraised by the Senior Independent Director, with support from the Lead Governor.

The Board has continued with TTI Development commissioned to provide Board development support to the Trust. In 2019/20 this has included an externally facilitated evaluation of the Board against the well-led framework.

Board meetings

The Board met on 11 occasions during 2019/20 to conduct its business. Our Board meetings are held in public. There are occasions where the Board meets in a confidential session due to the confidential nature of business discussed. The papers and minutes for those meetings held in public are published on the website: https://www.southernhealth.nhs.uk. At these meetings it takes strategic decisions and monitors the operational performance of the Trust, holding the Executive Directors to account for the Trust's achievements. As well as full Board meetings, the Trust holds regular Board focus meetings which members of the public are invited to attend. Three sessions were held during the year and discussions included the Communications Strategy, Primary Care Networks (PCNs) and UNLOC, diversity and inclusion, the Baby Friendly Initiative and the work of the Working in Partnership Committee.

Responsibilities for the operational and financial management of the Trust on a day-to-day basis rests with the Board of Directors, and all the powers of the Trust are vested in them.

The Standing Orders of the Trust require the Board of Directors to determine a schedule of matters on which decisions are reserved to itself, alongside a scheme of delegation. This is consistent with the NHS Foundation Trust Code of Governance, which requires that there should be a formal schedule of matters specifically reserved for decision by the Board of Directors, and that this should also include a clear statement detailing the roles and responsibilities of the Council of Governors.

This document sets out the powers reserved to the Board of Directors and those that the Board of Directors has delegated. Notwithstanding any specific delegation, the Board of Directors remains accountable for all of its functions, including those which have been delegated. Therefore, the Board of Directors will also expect to receive information about the exercise of delegated functions to enable it to maintain appropriate oversight.

All powers of the Trust, which have not been retained as reserved by the Board of Directors or delegated to a committee of the Board of Directors, shall be exercised on behalf of the Board of Directors by the Chief Executive or another Executive Director. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other Executive Directors, Non-Executive Directors or Officers. All powers delegated by the Chief Executive can be reassumed by him/ her should the need arise.

Board committees

In order to discharge its duties effectively, the Board is required to have a number of statutory committees, which include:

- Audit, Risk & Assurance Committee
- Charitable Funds Committee
- Nomination & Remuneration Committee

The Trust also has the following Board Committees in place to provide further assurance:

- Finance & Performance Committee
- Quality & Safety Committee
- Workforce & Organisational Development Committee
- Mental Health Legislation Sub-committee
- Transformation Steering Committee.
- Executive Management Committee (and successor Committees thereof due to changing governance arrangements in year)

The terms of reference define the membership for each committee. In addition to committee members, other staff are invited to attend to provide reports, advice and assurance.

Audit, Risk & Assurance Committee

This committee comprises three of our Non-Executive Directors. It is responsible for providing the Board of Directors with an independent and objective review of our financial and corporate governance, assurance processes and risk management across the whole of the organisation's clinical and non-clinical activities.

At each of the meetings, a range of internal audit reports were reviewed, including risk management, estates compliance, financial controls and data security and protection toolkit. Progress against any actions is monitored and challenged on a regular basis.

In relation to the 2019/20 financial year, the significant issues which the Committee members have considered in relation to the financial statements are the non-delivery of the control total and the impact of this on the Board's ability to sign off the accounts on a going concern basis. The Committee has also other areas of the Trust's overall governance and internal control procedures, and is confident that the Trust is well governed and that our internal control processes have improved significantly over the last three years; sources of external assurance, such as the CQC report, validate this.

The Financial Statements show a result which the Board has been aware of for many months. The publication of national data regarding the number of provisioned mental health beds and the adequate availability of "step down" services within Hampshire Social Services have been independently proven as below the national averages. The impact of these factors, alongside the block contract arrangements in place, are key reasons as to why the Trust failed to deliver the 2019/20 control total. The Board and ARAC consciously accepted the incremental costs associated with un-provisioned beds for the benefit, and proper care, of our residents of Hampshire.

The Committee took the view that it was appropriate to recommend to the Board to sign off on a going concern basis on the basis of the progress being made in terms of engagement with commissioners on the commissioning position and the operational improvements evidenced in many ways. Further detail on the Going Concern disclosure can be found on page 23.

In 2019/20 the Trust appointed BDO as the internal audit provider for the Trust following a competitive tendering process. The Head of Internal Audit reports to the Finance Director. The work of BDO is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

PricewaterhouseCoopers (PwC) is our external audit provider responsible for auditing and giving an opinion on the annual accounts each year. During 2019/20 PricewaterhouseCoopers has not provided any non-audit services for the Trust. The full fees for the services provided are set out in the financial statements. At the meeting in February 2020, the Council of Governors ratified the decision to extend the contract for PwC for a further year until November 2020; this was on the basis of a recommendation from the Chair of the ARAC which reflected the performance of the auditors and took account of the level of input, challenge, professionalism, objectivity, consistency and delivery in the service provided. The relationship between PwC and BDO is continually improving, for the benefit of the Trust, as BDO have just completed the first year of their contract. The Council of Governors will be asked to consider in 2020 whether to extend the contract for a final one-year term or to undertake a full procurement process.

Attendance of the members of the Committee is as follows:

Name	Meetings (attended/ eligible to attend)
David Kelham (Chair)	5/5
Jeni Bremner	5/5
Dr David Hicks	5/5

The Committee received and reviewed a number of different reports during the year, which included the Board Assurance Framework and risk register, information governance, procurement compliance, Freedom of Information Annual Report, encryption of patient records, legal services, use of RIO, non-patient courier contract, key financial systems, strategic governance, risk maturity and whistleblowing.

Charitable Funds Committee

The Charitable Funds Committee is responsible for monitoring the income and expenditure of charitable donations and for considering how charitable funds are invested. The Board is the corporate Trustee of the charitable funds.

Nominations & Remuneration Committee

The Nominations & Remuneration Committee fulfils the role of the Nominations Committee (for Executive Directors) and of the Remuneration Committee as described in the Trust's Constitution and the NHS Foundation Trust Code of Governance. The Committee approves the appointment of the Chief Executive Officer and Executive Directors, and makes decisions about their remuneration.

Quality & Safety Committee

The Quality and Safety Committee has responsibility for ensuring appropriate arrangements are in place for measuring and monitoring quality including patient safety and health and safety, for assuring the Board that these arrangements are robust and effective, and includes consideration of clinical governance matters.

Finance & Performance Committee

This Committee has responsibility for providing Trust Board with independent and objective oversight and assurance on the financial and operational performance of the Trust.

Workforce & Organisation Development Committee

This committee has responsibility for providing advice and assurance on the achievement of the Trust's People & Organisational Development Strategy. It must ensure the objectives of the strategy are, and continue to be aligned with the Trust's longer-term strategic plans.

Mental Health Legislation Sub-Committee

The Mental Health Legislation Sub-Committee provides assurances the Trust is operating and will continue to operate, in accordance with the law and best practice in relation to the rights of mental health.

Transformation Steering Committee

Established in 2018/19, this committee had responsibility for leading the implementation of the Trust's transformation programme, ensuring that all programmes collectively meet the strategic needs of the organisation. The committee is not a required statutory committee and became part of the Executive Management Committee in October 2019.

Executive Management Committee

This is the executive decision-making committee of the Trust and its purpose is to make management decisions on issues within the remit of the Executive Management, to support individual directors to deliver their delegated responsibilities by providing a forum for briefing and exchange of information and resolution of issues.

OUR APPROACH TO QUALITY AND CLINICAL GOVERNANCE

Good quality governance is maintained through the structures, systems and processes the Trust has put in place to ensure it manages the work effectively, scrutinises performance, manages risk, and deals with problems in line with NHS Improvement's Well-led framework.

For the Trust to be most effective, quality must become the driving force of the organisation's culture from service level to Board. Fundamental to creating this culture is our commitment to strengthen a number of ways that we can listen to patients and their families and carers, to understand what is important to them, what has gone well, and where we can improve.

It also means shifting the culture of decision making, giving staff the autonomy and confidence to make changes themselves where they know that outcomes can be improved for those who use their services.

This year we launched our new Quality Improvement Strategy which sets out our ambition for the next five years and describes what quality improvement means to us and how we are going to deliver sustainable change. For the first time, the new strategy describes formally the areas of:

- quality improvement methodology
- quality planning
- quality control
- quality assurance.

Our approach to achieving quality improvement is to adopt a systematic change methodology that is well understood, easily adopted and reflected in everything that we are and do, our culture, our people and our processes. This is supported by robust control and assurance mechanisms.

We have worked closely with our staff this year to engage them in the change methodology and train many staff to use it within their teams. It is imperative that this change is led by our staff, service users, carers and families. They know what we can change for the better and how we can do this. We have a dedicated Communications Manager to help facilitate this piece of work.

Within this strategy the quality priorities for 2019/20 are listed alongside the quality requirements from our contracts and improvement projects.

The delivery of these priorities is monitored by the Board through the Quality & Safety Committee. This is underpinned by the work of the Patient Experience, Engagement and Caring, Clinical Effectiveness and Patient Safety Groups who all have clinical representation.

The Trust's Quality & Safety Committee (QSC) is responsible for providing assurance to the Board of the delivery of the Trust's Quality Improvement Strategy, Patient Safety Commitment 2020 and People & Partnership Commitment 2018–2022 and ensuring that the objectives are aligned with the Trust's longer term strategic plans.

Each Division has local and specialist governance groups in place which monitor quality governance and continuous service improvement through quality improvement plans, peer review, incident reporting, investigations, complaints and patient/ staff feedback. These groups report in to the divisional Quality and Safety Meeting (QSM) who ensure the divisional approach to quality is patient and service user focused at all times.

QSM is also responsible for ensuring the Division has a clear and effective governance infrastructure in place for quality and safety with clear routes of escalation and dissemination. Performance against key indicators for Quality Governance are reported by each Division to the Executive Performance Review and any areas of concern are escalated to QSC.

MONITORING EFFECTIVENESS AND QUALITY

We use NHS Improvement's Well-led framework to ensure there are good governance procedures in place. The Well-led framework was reviewed as part of the CQC inspection which was undertaken in October 2019.

The inspection rated the Trust as 'Good' for the Well-Led aspect of the inspection. The inspectors recognised the Trust had a highly skilled, strong, stable and experienced senior team, including the Chair and Non-Executive Directors. They found the leadership team had taken significant steps to improve the culture across the Trust and this was paying dividends.

The inspectors stated that staff throughout the organisation knew and understood our vision and values and applied them to their work. Services within the organisation had a vision for what they wanted to achieve and a strategy to turn it into action.

More information on the Well-led framework can be found within the Annual Governance Statement on page 130.

Measurement

Measurement is a vital part of improvement; if we do not measure then we have no way of knowing whether the changes we are making are having an impact. Measurement is also one of the key elements of developing a safe culture. We have worked to develop a quality scorecard which enables the Board, senior managers and all staff to understand whether the care we are giving to our patients is as good as it can be.

Measurement is not just about performance metrics, it is also about learning and using a variety of information from different sources to gain an understanding of the care we are delivering. The Trust's quality governance team, performance team and leaders in our clinical Divisions, work together with staff to develop the use of measures and monitor the progress through our business intelligence reporting system, Tableau.

The Integrated Performance Report brings together this data and learning and is presented at Board along with a patient story to show how we are making changes due to feedback we receive.

Listening to patients, service users, their carers and families allows us to look at the effectiveness and quality of our services. The Trust is committed to working with people to involve them in their own care and treatment and to routinely offer opportunities for them to participate in planning, delivering, monitoring and improving our services. We ensure all changes to services are driven by feedback from the people who use our services and their carers and families. The Trust has appointed service user facilitators, experts by experience and peer support workers to support this.

Inspection and review tools

We use a number of internal inspection and review tools, along with external inspections and reviews to help gauge our performance and make improvements.

Complaints

We strive to provide high quality care and treatment to all our service users, however, we recognise that we will not always meet people's expectations. We consider all feedback important and welcome all constructive feedback to help us learn and continuously improve our services.

Listening to people's experiences is a vital tool in gauging how well the Trust is providing services and how we can improve for the future.

It is important we have a clear process for feedback to ensure any concerns and complaints are dealt with efficiently and effectively. The way in which feedback is dealt with must take the complainant's preferences into account and ensure they are placed at the centre of all work carried out to investigate their issues and feedback to them. The Trust is committed to listening carefully and responding immediately, whenever possible, to resolve any issues.

We are committed to responding to complaints in a fair, impartial and transparent way and within a reasonable timeframe. The Complaints and Patient Experience Team attended a Quality improvement week in March 2019, which involved service users, carers and staff across the Trust and have made some positive changes as a result of this workshop. As a result of the Quality Improvement week, several changes were implemented, which have shown a positive improvement in the overall experience. For example, we now ask the complainant who they would like to sign their final response letter. This allows them the choice, and also ensures the service is taking full accountability for the leaning and actions identified within the complaint. We have rewritten our complaints leaflets and posters, changing the wording from "Have your say" to "We'd love to hear from you". We wanted to make sure anyone who uses our services, feels welcome to share their feedback with us. The Complaints Policy and Procedure has also been reviewed, with the support of our Working in Partnership Committee. We have also changed our acknowledgement letter, and final patient experience survey, both of which were rewritten during the quality improvement week, with the support of previous complainants. In October 2019, the team moved under the leadership of the Head of Patient and Public Engagement and Patient Experience, which has enabled us to work more closely with the wider patient experience team. The complaints and patient experience team manager spent some time visiting services with high volumes of complaints, to speak to them about local resolution, and how they can reduce potential complaints at the first point of contact. As a team, we will continue to speak with our complainants and work with our services to support local resolution and to review potential improvements for the future.

MEMBERSHIP

We encourage our local residents to register as member to have a say in Trust developments and to ensure the Trust is accountable to local populations. Our membership is divided into public and staff constituencies.

Public constituencies

Our public membership is divided into five constituencies based on local government boundaries. Anyone aged 14 years or over who lives in England, and who does not meet the eligibility for a staff member, can become a member of the Trust.

As of 31 March 2020 there were **8341** public members of the Trust.

- Public membership numbers by constituency:

North Hampshire	1730
South East Hampshire	1234
South West Hampshire	2501
Southampton	1861
Rest of England	1015

- A map to show the public constituency areas for our membership:

Staff constituency

The staff constituency is divided up into four areas based on the geographical boundaries of the public constituency areas:

- North Hampshire
- Southampton
- South West Hampshire
- South East Hampshire

Staff must be employed by Southern Health on a permanent contract or have worked at the Trust for at least 12 months to qualify as a member of the staff constituency.

Our membership strategy

Southern Health is committed to meaningful engagement with patients, the public and our local communities. We have, and continue to, carry out significant work to develop and improve this important area. Engagement and recruitment of Foundation Trust Members is part of this wider priority.

Members are a key stakeholder group identified in our communications strategy and our patient engagement strategy, and the Trust seeks to engage with this group in a number of ways. This includes regular newsletters, the Annual Members Meeting, and updates about key changes and developments. The Trust has a database of members which includes demographic information which can be used to understand the diversity and representation within our member population. This information can be used to target membership recruitment to particular events or opportunities.

The Trust recognises that more can be done to engage members in the context of wider patient and public engagement. Looking ahead, the Trust intends to develop its membership approach, aiming to build a more active, engaged and representative membership population.

Become a member!

If you are interested in helping to shape your local NHS Services, please join us:

Telephone: **023 8087 4666**

Email: **ftmembership@southernhealth.nhs.uk**

Online: **www.southernhealth.nhs.uk**

Council of Governors

The Council of Governors (CoG) is an essential link between our membership and Board to help ensure everyone's views are heard. Although the Council is not involved in the operational management of the Trust, it is responsible for holding the Non-Executive Directors to account for the performance of the Trust Board in delivering the Trust's strategic objectives and for representing interests of members and the public. The Scheme of Delegation and schedule of Board reserved powers includes a statement on the role and responsibilities of the Council of Governors. More about the responsibilities of our CoG can be found at: https://www.southernhealth.nhs.uk

Our CoG consists of 22 members (as at 31 March 2020 there were seven vacancies on the Council of Governors and 15 Governors in post):

- **13** public Governors who represent our public constituencies
- **4** staff Governors who represent our staff
- **5** appointed Governors who represent organisations or partners that we work closely with.

Governors were provided with an opportunity, through Governor development sessions, to learn more about the Trust's forward plans, in the context of the broader NHS system by inviting them to attend and feed back at Board and Committee meetings, they were able to communicate their own, and any member or partner organisation comments on the Trust's forward plans and underpinning strategies.

Meetings of the Council of Governors

Our CoG meet in public on a quarterly basis where members consider the performance of the Trust, highlighting any issues or concerns they may have in relation to the way in which the Board of Directors is managing performance.

Contacting a Governor

Anyone wanting to get in contact with our governors can email the Corporate Governance Team on:
corporate.governance@southernhealth.nhs.uk

or visit our website for details on how to contact governors directly:
https://www.southernhealth.nhs.uk/about/council-of-governors/

Elected public constituency	Name	Initial term commenced	Current term ends/ ended	Term	Council of Governors (attended/ eligible to attend)
Southampton	Andrew Jackman (Lead Governor)	25 July 2011	24 July 2020	3	4/4
	Paul Lewzey	02 August 2018	01 August 2021	1	4/4
	Denise Wyatt*	17 July 2018	resigned 05 April 2019	1	0/0
South West Hampshire	Josephine Metcher	21 July 2015	20 July 2021	2	2/4
	Dave Cubbon*	21 November 2017	resigned 11 October 2019	1	1/3
	Peter Smith	05 November 2018	04 November 2021	1	3/4
North Hampshire	David Lee	13 October 2016	12 October 2019	1	2/2
	Venus Madden	13 October 2016	14 January 2023	2	2/4
	Lilian Turner*	06 December 2018	resigned 22 October 2019	1	3/3
South East Hampshire	Gary Butler	17 May 2017	16 May 2020	1	0/4
	Suzanne Pepper*	01 July 2019	30 June 2022	1	3/3
	Robert Blackman*	18 December 2019	17 December 2022	1	1/1
	Malcolm Carpenter*	17 May 2017	resigned 15 August 2019	1	0/2
Rest of England	Michael North*	01 July 2019	30 June 2022	1	3/3

* in post for part of the year

A term of office for a public elected Governor, as specified within the Constitution, is three years.

Elected staff class	Name	Initial term commenced	Current term ends/ ended	Term	Council of Governors (attended/ eligible to attend)
South West Hampshire	Margaret Martins	08 August 2017	7 August 2020	1	4/4
North Hampshire	Louise Vinell	22 October 2018	21 October 2021	1	3/4
Southampton	Gemma Surridge*	01 July 2019	30 June 2022 No longer eligible for this staff class as of 5 March 2020 due to change in role	1	3/3
South East Hampshire	Vacancy				

* in post for part of the year

Appointed Governors	Name	Initial term commenced	Current term ends/ ended	Term	Council of Governors (attended/ eligible to attend)
Carers Together	Adrian Thorne	01 March 2016	28 February 2022	2	4/4
Hampshire County Council	Cllr Rob Humby	21 November 2017	20 November 2020	1	4/4
Southampton City Council	Cllr Lorna Fielker	06 December 2018	5 December 2021	1	2/4
University of Southampton	Prof David Baldwin	13 April 2017	12 April 2020	1	2/4
Age Concern Hampshire	Vacancy				

* in post for part of the year

In addition to the business transacted at meetings listed above the Council of Governors approved a number of written motions in March 2020. Further information on the work of the CoG is provided on page 78.

Our Lead Governor

In 2019, Andrew Jackman was re-appointed as Lead Governor with effect from 18 August 2019 for a term of one year. In his role as Lead Governor he has attended Trust Board meetings, held discussions with Governors in private, and where required, brought these to the attention of the Chair to raise any issues or to seek clarity. He has also attended a number of externally held conferences and is engaged in the National Lead Governors Association.

Governor elections

Elections were held in July 2019 and January 2020 where a number of new Governors were elected, as set out in the table on pages 76 and 77. As of 31 March 2020, the Trust held a number of Governor vacancies. Elections to fill these vacancies will take place as soon as is possible.

Board and Governors working together

Our Trust Chair is responsible for the leadership of both the CoG and the Trust Board. There are regular opportunities for Governors to meet with Non-Executive Directors, Directors and Trust staff through Governor development days, CoG meetings, or on a collective/ individual basis with either the Chair or the Senior Independent Director if they wish.

In 2019/20, we held three confidential meetings between the Governors and Non-Executive Directors. An open and honest debate was held on Governor involvement in the Hampshire and Isle of Wight Sustainability and Transformation Partnership, support provided to staff governors, the Chair and Non-Executive Director appraisal process and discussions around the strategic plan for the Trust.

Concerns can be raised through the Senior Independent Director, any Director of the Trust or through the Associate Director of Corporate Affairs (Company Secretary).

Some examples of how our CoG and Board have worked together this year include:

- confidential meetings between Governors and Non-Executive Directors
- Executive and Non-Executive Directors attending each CoG meeting
- summary reports from Board Committees presented by the Committee Chair to each CoG meeting
- Governors invited to attend the confidential session of Trust Board meetings (in addition to the public sessions)
- CoG receiving the agenda and minutes of the public and confidential Trust Board meetings
- Governors being invited to observe and contribute at all Board Committee meetings (with the exception of the Nomination & Remuneration Committee and the Executive Management Committee).

In 2019/20 the CoG has:

- received family and carer stories
- reviewed and approved changes to the constitution
- been consulted on the selection of an indicator for auditing for the Trust's Quality Report 2018/19
- reviewed and approved the Chair and Non-Executive Director remuneration policy
- reviewed and approved the Lead Governor nomination and election process
- approved the reappointment of Lynne Hunt as Chair for a three-year term with effect from July 2020
- approved the reappointment of David Kelham as Non-Executive Director for a three-year term with effect from July 2020
- approved the reappointment of David Monk as Non-Executive Director for a one-year term with effect from July 2020
- approved the appointment of Ron Shields as Chief Executive
- approved the extension of the contract with PricewaterhouseCoopers for a further year.

In 2019/20 the Governors have not exercised their power, under paragraph 10C of Schedule 7 of the NHS Act 2006, to require one or more of the directors to attend a CoG meeting to obtain information about the performance of its functions or the directors' performance of their duties. If any disputes arise between our CoG and Board of Directors, then the disputes resolution process as described in the Trust Constitution would be followed. During 2019/20, this process has not been required.

Appointment Committee

The CoG has established an Appointment Committee to recommend the appointment of the Chair and Non-Executive Directors to the CoG, including recommendations on remuneration. The committee membership is made up of Governors and a Non-Executive Director (usually the Chair).

The committee is responsible for:

- ensuring there is a formal, rigorous and transparent procedure for the selection of the candidates for office as Chair or Non-Executive Director of the Trust
- ensuring any search for candidates for the role of Chair or Non-Executive Director is conducted against objective criteria with due regard for the benefits of diversity on the Board and the requirements of the Trust
- preparing and reviewing the description of the role and capabilities required for the Non-Executive Directors, including the Chair
- agreeing the timetable and action plan for appointment
- identifying and nominating candidates for the Chair or Non-Executive Director roles and making recommendations of potential candidates for appointment
- regularly reviewing the structure, size and composition of the Board of Directors
- considering and making recommendations to the CoG as to the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors.

Membership of the Appointment Committee during 2019/20 and attendance of Governors at the meetings is as follows:

Name	Meetings (attended/ eligible to attend)
Lynne Hunt, Chair	2/2
Robert Blackman, Public Governor, South East Hampshire	2/2
Councillor Lorna Fielker, Appointed Governor, Southampton City Council	1/2
Councillor Rob Humby, Appointed Governor, Hampshire County Council	1/2
Andrew Jackman, Public Governor, Southampton	2/2
Paul Lewzey, Public Governor, Southampton	2/2
Venus Madden, Public Governor, North Hampshire	1/2
Margaret Martins, Staff Governor, South West Hampshire	2/2
Josie Metcher, Public Governor, South West Hampshire	2/2
Michael North, Rest of England	2/2
Suzanne Pepper, South East Hampshire	1/2
Gemma Surridge, Staff Governor, Southampton	1/2
Peter Smith, Public Governor, South West Hampshire	2/2
Adrian Thorne, Appointed Governor, Carers Together	1/2
Louise Vinell, Staff Governor, North Hampshire	1/2

In addition to the meetings listed above, in March 2020, the Appointment Committee approved a written motion to recommend to the Council of Governors the re-appointment of David Kelham and David Monk as Non-Executive Directors from the end of their term of office in July 2020.

Chair and Non-Executive Director appointments and remuneration

In 2019/20, the following recommendations made by the Appointment Committee were approved by the Council of Governors:

- the re-appointment of the Trust Chair
- Chair and Non-Executive Director Remuneration Policy
- the re-appointment of two Non-Executive Directors

Our Constitution explains how a Board member may not continue in the role. It also outlines additional provisions for the removal of the Chair and Non-Executive Directors, which requires the approval of three-quarters of the members of the CoG.

If any proposal to remove a Non-Executive Director is not approved at a meeting of the CoG, no further proposal can be put forward to remove the Non-Executive Director based upon the same reasons within 12 months of the meeting.

Stakeholder relations

We provide a diverse range of services to a large population over a wide geography. Many individuals, groups and organisations are affected, or can affect our work. Furthermore, there are clear benefits to be gained from involving patients, carers and the public in the design and delivery of local health services. So, we are committed to building and maintaining meaningful and constructive relationships with all our key stakeholders.

We keep stakeholders informed through a bi-monthly newsletter that was established over the last 12 months. The newsletter updates our stakeholders about key progress, successes and also challenges that we are working to overcome. In addition to this we issue specific briefings to key stakeholders around key developments or announcements.

We regularly and proactively keep local Overview and Scrutiny Committees informed of any key developments, through briefings and presentations to the panels. This is to ensure that we are carrying out appropriate engagement and consultation.

We maintain regular correspondence with MPs and other political colleagues, particularly those with an interest or portfolio related to health. We have attended a number of MP public forums and meetings to engage local constituents about health services. Furthermore, we have hosted visits to our services from local MPs – including our Melbury Lodge in Winchester, Parklands Hopsital in Basingstoke, and the opening of a new Low Secure Forensic Service at Tatchbury Mount, over the last 12 months.

We carry out an annual audit of our stakeholders' attitudes towards the organisation. The results for last year showed that broadly our stakeholders felt that the Trust was making improvements, communicating well and involving people in decisions, but with room for improvement in all areas. The audit also provided useful feedback on where we can improve our stakeholder engagement, which we have acted upon and hope to see reflected in this years' stakeholder audit results.

Further information about our relations with key stakeholders can be found throughout the Annual Report including on pages 34, 35, 36, 42, 43, 44, 45 and 46.

We have a number of strategic partnerships with key stakeholders. A few key examples are highlighted below:

- We are a partner organisation in the Hampshire and Isle of Wight Sustainability and Transformation Partnership (HIOW STP), which involves all the local health and care providers and commissioner in the region. The HIOW STP organisations work together to identify priorities for improving health and care in a number of key areas. We are particularly involved in the mental health programme of the HIOW STP, and play a central role in a number of initiatives.

- We have continued our partnership with Northumberland, Tyne and Wear (NTW) NHS Foundation Trust, which provides similar services to Southern Health. We have been working with NTW to progress our Quality Improvement (QI) programme. Although we are now delivering the QI programme without direct input from NTW, the organisation has proved invaluable in helping us to become self-sufficient in our QI approach.

- We have been working closely with Hampshire County Council in the design and development of our Immediate Integrated Care programme. This looks at improving and joining up services between health and social care services to prevent hospital admissions. More information about this project can be found on page 46.

- We have developed our partnership with Unloc, a youth-involvement social enterprise. We have expanded our inreach into schools and colleges to talk about topics such as mental health and NHS careers, and established a Youth Board to ensure that young people have a greater voice in shaping our services.

- Our most important stakeholders are our patients, their families and our staff. Over the last year we have developed our relations with these key groups in a number of ways. Through our User Involvement Facilitators and via our Working in Partnership Committee we have increased co-production and service user involvement; for example in the creation of better information for patients and carers. Staff engagement is key to improved patient outcomes and our staff survey results have shown a further improvement in staff engagement levels over the last year. This has been the result of a significant programme of engagement and communication activity with our staff, from the board to the ward level.

- We also work closely with our consultative and negotiating forum: Local Negotiating Committee (LNC) (for medical and dental staff) and Joint Consultative and Negotiating Committee (JCNC) (for all other staff).

More information about our work with these forums can be found on page 104.

Disclosures

After review, the Trust can confirm there are no inconsistencies between the annual governance statements, the corporate governance statement submitted with the annual plan, annual reports and reports arising from the Care Quality Commission.

Statement as to disclosure to auditors

As far as the Directors are aware, all relevant information has been made available to the auditors. The Directors have also taken necessary steps in their capacity as Directors and are unware of any relevant information not being disclosed or brought to attention of the auditors.

Cost allocation and charging

We have complied with the cost allocation and charging requirements set out in Her Majesty's Treasury Information Guidance.

Income from the provision of goods and services

As per section 43 (2A) of the NHS Act (amended by the Health and Social Care Act 2012), we can confirm the income from the provision of goods and services for the purpose of the health service in England is greater than income from goods and services for any other purpose. Income from other goods and services has had no adverse impact on the delivery of goods and services for the purposes of the health service in England.

Better payment practice code

	31 March 2020 YTD number	31 March 2020 YTD £
Non NHS		
Total bills paid in the year	37,497	£109,225,955
Total bills paid within target	35,211	£105,592,064
Percentage of bills paid within target	93.9%	96.7%
NHS		
Total bills paid in the year	2,483	£31,738,579
Total bills paid within target	2,064	£28,182,774
Percentage of bills paid within target	83.1%	88.8%
Total		
Total bills paid in the year	**39,980**	**£140,964,534**
Total bills paid within target	**37,275**	**£133,774,838**
Percentage of bills paid within target*	**93.2%**	**94.9%**

*The target is to pay 95% of invoices by volume and value within 30 days.

Comparative 2018/19 performance showed 93.2% of bills paid within target (36,101 of 39,980). The value of these was 94.8% of bills paid were within target (115,551,000 of 121,920,000).

The Trust endeavours to pay all invoices within the 30 day target, more than the **95%** objective directed by the government. However there are some instances where this has not been achieved despite our best efforts. This has resulted in an estimated liability to pay interest which was accrued by virtue of missing the target of **£32k** in 2019/20; however the total amount of interest charged was nil.

Fees and charges

We have no material fees and charges in the period (in excess of **£1m**) from any income generation activities.

Political and charitable donations

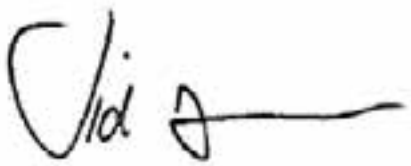
We have not made any political or charitable donations during 2019/20.

Directors' responsibilities for preparing the accounts

The Directors are responsible for preparing the Annual Report and Accounts. We consider 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 Trust's performance, business model and strategy.

The Accountability Report also encompasses sections 2.2, 2.3, 2.4, 2.5, 2.6 and 2.7.

Signed:



Dr Nick Broughton, Chief Executive

2 June 2020

2.2 REMUNERATION REPORT

Annual statement from the Chair of the Nominations & Remuneration Committee

I confirm that I was the Chair of the Nominations & Remuneration Committee from 1 April 2019 and present to you the Annual Report on remuneration for the financial period 2019/20 on behalf of the committee.

The Nominations & Remuneration Committee is established by the Board of Directors and reviews the remuneration, recruitment, appraisal and terms of service for Executive Directors and any other such senior managers.

Major decisions on remuneration in 2019/20

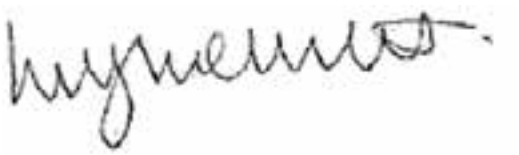
The Nominations & Remuneration Committee aims to ensure Executive Director remuneration is set appropriately, taking into account relevant market conditions. Executive Directors should be appropriately rewarded for their performance against goals and objectives linked directly to the Trust objectives, but not paid more than is needed.

After careful consideration of national guidance and benchmarking, the committee decides what level of increase in remuneration is appropriate. The committee ensures that any increase is fair and reflects benchmarking of executive pay across the NHS.

During the year the Nominations & Remuneration Committee considered the Executive Team structure and approved the following:

- the recruitment process, appointment of, and the remuneration for the Chief Operating Officer and the Director of Strategy & Infrastructure Transformation
- a review of the remuneration for the Finance Director and the Director of Nursing & Allied Health Professionals
- the remuneration and allocation of Board voting rights for the Director of Workforce, Organisational Development & Communications as a full Executive Director
- the updated Executive Director Remuneration Policy
- the pension contribution alternative award policy
- Executive objectives for 2020/2021
- the local Mutually Agreed Resignation Scheme programme (with approval sought from NHS Improvement, acting with delegated authority from HM Treasury)
- any cases for performance related pay
- any redundancy business cases where the value has exceeded **£50k**
- any inflationary pay awards for any staff groups on local terms and conditions.

Signed:



Lynne Hunt, Chair

2 June 2020

REMUNERATION REPORT (CONTINUED)

General Data Protection Regulation

In light of the General Data Protection Regulation (GDPR) we have contacted (or attempted to contact) all persons named in this report that we intend to publish information about them. We have advised them they are able to object to this publication under Article 21 of the General Data Protection Regulation.

Senior managers' remuneration policy

Our Executive Director Remuneration Policy sets out the remuneration arrangements for Southern Health Executive Directors and other very senior managers not on national terms and conditions of service.

For Executive Directors their remuneration is determined by the Nominations & Remuneration Committee rather than national terms and conditions of service (TCS). The Nominations & Remuneration Committee has the delegated power to act on behalf of the Board in making decisions upon the remuneration and terms of service for the Chief Executive and other Executive Directors.

These decisions will cover all aspects of salary, including performance-related elements or bonuses (if applicable), the provisions of other benefits, the approval of arrangements for termination of employment and other major contractual terms.

The Executive Director Remuneration Policy, was updated in November 2019 and shared with the Joint Consulting & Negotiating Committee before publication. The policy is in line with the Fair and Equal Pay Act and in line with the Foundation Trust duties under the Equality Act 2010 and the Public Sector Equality Duty.

As a guide for the appropriate remuneration level, NHS Improvement issue 'established pay ranges for acute Trusts and NHS Trusts'. The Trust's Nominations & Remuneration Committee use this as a framework for determining Executive Director salaries and consider the section most relevant for the Trust, which is currently "Medium Mental Health FTs and Trusts (over £200m turnover)".

The median to upper quartile salary level for each post will be applied unless the committee agree that there are specific reasons why remuneration for a particular post should be higher or lower (such a reason could be a broader portfolio of responsibilities for a Director within this Trust compared to a typical Director with that title across most other Trusts).

In addition, the Trust may consider other market factors such as remuneration levels within neighbouring Trusts/ arms-length bodies which recent history tells us are the key competitors and suppliers of our very Senior staff.

All remuneration decisions will need to take into consideration affordability. It may be noted that remuneration levels could be increased according to the criteria set out in this policy but that this is not affordable by the Trust at the time of the review. Where this is the case a date should be agreed for a further review.

There is no bonus related pay scheme for Executive Directors, in line with other staff within the Trust, but for some Executive Director roles an earn-back element is included as part of their remuneration package.

The National Pay Review Bodies consider factors relevant to determination of appropriate terms and conditions of service (including an annual cost of living award) for staff on national terms and conditions of services; the Executive Director Remuneration Policy sets out the role of the Nominations & Remuneration Committee to undertake this review annually.

The Executive Director Remuneration Policy was developed, taking account of the provisions of the Workforce Remuneration Policy, whilst also ensuring compliance with the guidance as issued by NHS Improvement.

Reflecting the policy commitment to remuneration under national terms and conditions of service, including the utilisation of the pay flexibilities within these national frameworks and those locally agreed in order to ensure this best enables us to deliver our vision and strategic priorities, the Executive Director Remuneration Policy follows the NHS Improvement published established pay ranges, but recognises the need for flexibility within these ranges when agreeing individual Director remuneration.

Senior Managers' Remuneration Policy table

The table on page 87 highlights the components of Directors' pay, how we determine the level of pay, how change is enacted and how Directors' performance is managed.

Future Policy table

The Future Policy table below highlights the components of Directors' pay, how we determine the level of pay, how change is enacted and how Directors' performance is managed.

Component	Salary and Fees
How the component supports the strategic objective of the Trust	We recognise the overriding objective of our remuneration policy should be to ensure the Trust employs and retains competent and appropriately remunerated staff at all levels to enable the successful delivery of the Trust's objectives and sustainability of the organisation.
How the component operates	Executive Directors and (under exceptional circumstances) other very senior managers will be paid outside of Agenda for Change terms and conditions.
Maximum that could be paid	No set maximum. In rare circumstances, the basic level of remuneration will be considered insufficient to attract or retain the appropriate candidate for an Executive Director post. In such circumstances, other market factors such as remuneration levels within neighbouring Trusts/ arms-length bodies would be considered since these organisations are key competitors in this respect. The level of remuneration in these circumstances will be linked to an earn back element which is dependent on the incumbent achieving objectives set by the Chief Executive, or in the case of the Chief Executive, set by the Chair in agreement with the Nominations & Remuneration Committee. There are earn back arrangements in place for Dr Karl Marlowe and Dr Nick Broughton, but they have not been invoked.
Description of framework used to assess performance	Each Senior Manager is reviewed annually for delivery of individual objectives, along with an assessment of performance against the behavioural framework for Executive Directors as measured through the annual appraisal process.
Amount that may be paid; min level of performance in any payment under this policy; any further levels of performance set in accordance with the policy	Whilst remuneration levels for the majority of Trust staff employed on the Agenda for Change framework are set by the national pay review body, salaries payable to Executive Directors are determined by the following criteria: • the median remuneration level for a Director post of that type as described in the NHS Improvement 'established pay ranges for combined Mental Health Trusts and NHS Trusts' document • any broader/ lesser portfolio responsibility which may require payment above or below the median level • any other reason relating to the Trust or individual Director post requiring remuneration above or below the median level • the market value according to a comparison of remuneration levels across the local area. A pay award is considered by the Nomination & Remuneration Committee where individuals can evidence that they have achieved or exceeded performance objectives.
Provisions for the recovery of sums paid to directors and for withholding payments of sums to senior managers	The recovery of any erroneous overpayment of salary is in line with the Trust policy on salary over/ under payments. The Executive Director Remuneration Policy outlines the approach for the inclusion of an earn-back clause within Director's contracts and the process by which this is determined

The Council of Governors is responsible for setting the terms and conditions of the Non-Executive Directors, including the Chair. The table below sets out the remuneration and key terms and conditions:

Role	Remuneration	Time Commitment	Notice period
Chair	£60k	3 days a week	4 months
Deputy Chairman	£15k	2/3 days a month	4 months
Senior Independent Director	£15k	2/3 days a month	4 months
Audit Committee Chairman	£15k	2/3 days a month	4 months
Chairman of other Board Committee	£15k	2/3 days a month	4 months
Non-Executive Director	£13k	2/3 days a month	4 months

Non-Executive Directors can reclaim any essential expenses incurred as part of their role; they do not receive any benefits in kind.

Directors with remuneration (total) greater than £150k

Remuneration is regularly benchmarked across peer UK NHS organisations. We continue to seek the opinion of the Department of Health via NHS Improvement for any posts with a remuneration exceeding **£150k**.

Diversity and inclusion policy for remuneration committee

Our Board-approved People & Organisational Development Strategy, which was refreshed in 2019, has clear diversity and inclusion targets, including an overarching aim to ensure our staff are representative of the communities we serve at all levels by 2024/25. The strategy sets out our "offer" and milestone measurements to achieve this. The commitments include:

- Equality of opportunity for promotion within the Trust
- Improved gender equality of pay
- All interviews with declared diverse candidates to contain diversity in the panel
- Reverse mentoring and Ally training (this training recognises ones privilege and becoming Allies in the workplace) within services where negative behaviour has been identified
- Unconscious bias training embedded into all management and leadership curricula
- Disability and Mental Health review of the sickness absence policy and guidance issued for managers of disabled staff to ensure adaptations are met
- Visual campaign "It's not ok" to target violence and discrimination cases against our single equality staff groups
- A clear pathway of employment for people with lived experience and learning disability.

Progress on achieving the milestone measurements is monitored by the Workforce & Organisational Development Committee.

Service contract obligations

The Trust does not stipulate any special terms in relation to severance arrangements for Directors. In any occasion of termination of a contract, Directors would not be treated differently from any other member of staff.

Policy on payment for loss of office

We do not have a specific policy relating to the payment for loss of office. Loss of office for senior managers would be managed under the Organisational Change Policy which deals with redundancy and redeployment. Redundancy pay would comply with both Agenda for Change provisions and legislative requirements.

Where any discretion is applied this will always be in accordance with the individual's contractual terms and approved through a legally-determined Settlement Agreement.

We ensure that we comply with the Nominations & Remuneration Committee terms of reference for approval for redundancy, severance or loss of office payments for any staff reporting directly to the Chief Executive or another Executive Director, or where the value exceeds **£50k**, or where the business case requires reporting to HM Treasury.

ANNUAL REPORT ON REMUNERATION

Service contracts

Executive Directors are employed on contracts with a notice period of six months. We do not have any fixed terms for our current directors. Their dates of employment can be found below.

Director job title	Start date
Chief Executive	06 November 2017
Chief Operating Officer	04 November 2019
Director of Workforce, Organisational Development and Communications	01 January 2018
Finance Director	05 September 2016
Chief Medical Officer	09 April 2018
Director of Nursing and Allied Health Professionals	28 July 2018
Director of Strategy and Infrastructure Transformation	05 August 2019

Our Non-Executive Directors are appointed for a term determined by the Council of Governors (usually for a term of 1–3 years).

Nominations & Remuneration Committee

The Nominations & Remuneration Committee met eight times during 2019/20 and also transacted business via approval of a written motion in March 2020. It considers the terms and conditions of appointment of all Executive Directors, and the appointment of the Chief Executive and other Executive Directors.

The membership of the committee is detailed below and although Executive Directors may be invited to attend committee meetings, they are not members of the committee (except for the appointment of Executive Directors where the Chief Executive is a member).

Name	Meetings (attended/ eligible to attend)
Lynne Hunt, Non-Executive Director	8/8
Michael Bernard, Non-Executive Director	5/5
Jeni Bremner, Non-Executive Director	7/8
Kate Fitzgerald, Non-Executive Director	4/5
Rob Goldsmith, Non-Executive Director	7/8
Dr David Hicks, Non-Executive Director	6/8
David Kelham, Non-Executive Director	7/8
David Monk, Non-Executive Director	6/8

Although not members, Directors and Officers attended the Nominations & Remunerations Committee to provide information and advice when required. The Chief Executive, Finance Director, Associate Director of Corporate Affairs (Company Secretary) and Director of Workforce, Organisational Development and Communications attended meetings of the committee during the year to fulfil this requirement. The Chief Executive attended as a member of the Committee for those decisions relating to the appointment of the Director of Strategy and Infrastructure Transformation and the Chief Operating Officer.

Disclosures required by the Health and Social Care Act

The Trust has a Workforce Remuneration Policy which provides a remuneration framework to ensure the Trust employs and retains competent and appropriately remunerated staff at all levels. This allows the successful delivery of the Trust's objectives and sustainability of the organisation. The policy ensures transparency with regard to remuneration arrangements for Trust employees, with particular clarity where decisions are subject to national or local decision. The Trust's Nomination & Remuneration Committee review the Workforce Remuneration Policy and also make decisions regarding any elements which are outside of the policy eg "Golden Handshake" payments. Executive pay is monitored by the Nominations & Remuneration Committee and is applied in line with NHSI Guidance.

Directors and Governor Expenses

	Year	Number in post	Number who claimed	Amount claimed £ (to the nearest £100)
Executive Directors	2018/19	10	10	27,100
	2019/20	8	7	13,300
Non-Executive Directors	2018/19	6	6	17,900
	2019/20	8	7	15,200
Governors	2018/19	22	12	6,000
	2019/20	21	9	6,000
Total	**2018/19**	**38**	**28**	**51,000**
	2019/20	**37**	**23**	**34,500**

Senior manager remuneration and benefits - the information in this section is subject to audit

- Calculations for Senior Manager Disclosures 2019/20:

Name and title	Real increase in pension at pension age a (bands of £2,500)	Real increase in pension lump sum at pension age b (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 c (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 d (bands of £5,000)	Cash Equivalent Transfer Value at 01 April 2019 e £ 000's	Real Increase in Cash Equivalent Transfer Value f £ 000's	Cash Equivalent Transfer Value at 31 March 2020 g £ 000's
Dr. Nick Broughton	0	0	60–65	190–195	1,286	13	1,345
Paula Anderson	0–2.5	0	30–35	55–60	537	25	589
Paula Hull	2.5–5	0–2.5	40–45	95–100	730	46	812
Dr. Karl Marlowe	2.5–5	5–7.5	40–45	120–125	774	64	879
Heather Mitchell	0–2.5	0	20–25	0	204	16	250

- Final summary 2019/20:

Name and title	Office	2019/20					
		Salary £ 000's (bands of £5,000)	Taxable Benefits £'s (to the nearest £100)	Annual Performance-related Bonuses £ 000's (bands of £5,000)	Long-term Performance-related Bonuses £ 000's (bands of £5,000)	Pension Related Benefits Restated £ 000's (bands of £2,500)	Aggregate £ 000's (bands of £5,000)
Lynne Hunt	Chair	55–60	0	0	0	0	55–60
Jennifer Bremner	Non-Executive Director	10–15	0	0	0	0	10–15
Dr David Hicks	Non-Executive Director	10–15	0	0	0	0	10–15
David Kelham	Non-Executive Director	10–15	0	0	0	0	10–15
David Monk	Non-Executive Director	10–15	0	0	0	0	10–15
Robert Goldsmith	Non-Executive Director	10–15	0	0	0	0	10–15
Michael Bernard	Non-Executive Director	10–15	0	0	0	0	10–15
Kate FitzGerald	Non-Executive Director	10–15	0	0	0	0	10–15
Dr Nick Broughton[1,2,3]	Chief Executive	210–215	1,700	0	0	0	215–220
Paula Anderson[1,5]	Finance Director	155–160	1,300	0	0	25–27.5	185–190
Paul Draycott	Director of Workforce and OD	115–120	2,100	0	0	0	115–120
Paula Hull	Director of Nursing and Allied Health Professionals	125–130	1,600	0	0	47.5–50	170–175
Dr Karl Marlowe[6]	Medical Director	185–190	0	0	0	67.5–70	255–260
Barry Day[4]	Chief Operating Officer	65–70	400	0	0	0	65–70
Grant Macdonald	Chief Operating Officer	55–60	400	0	0	0	55–60
Heather Mitchell	Director of Strategy and Infrastructure Transformation	80–85	600	0	0	52.5–55	130–135

1. These officers opted out of the NHS Superannuation scheme during 2019/20 financial year, Dr. Nick Broughton on 01 August 2019 and Paula Anderson on 31 December 2019.
2. Pension related benefits have resulted in a negative change, in compliance with reporting regulations this is represented with zero value.
3. Dr Nick Broughton has signed up to the Pension Contribution Alternative Award Policy offered by the Trust, £5k–£10k.
4. The amount disclosed for 2019/20 includes contractual Payment in Lieu of Notice £25k–£30k
5. Paula Anderson received a non recurrent allowance in recognition of covering the Chief Operating Officer role whilst it was vacant, £10k–£15k.
6. Dr Karl Marlowe's remuneration includes the allocation of two clinical programmed activities related to his clinical role 2019/20 £25k–£30k.

◆ Median Pay Multiplier

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director in their organisation and the median remuneration of the organisation's workforce. The highest paid Director is in the band **£210k–£215k** and results in a ratio of 6.92 (2018/19 the band **£200k–£205k** and ratio 6.84)

- In 2019/20 no employees received remuneration in excess of the highest-paid director, (2018/19, nil).
- The median pay calculation is based on the payments made to staff in post on 31 March 2020.
- The reported salary used to estimate the median pay is the gross cost to the Trust, less employer's pension and employers social security costs.
- The reported annual salary for each whole time equivalent has been calculated by taking the cumulative cost for each employee to March 2020 from the Trust's electronic staff record.
- Payments made throughout the year to staff who were part time have been pro-rated to the equivalent annual whole time salary.
- Included in the calculation is an estimated average cost for agency & bank staff. All agency and bank staff expenditure is processed through dedicated account codes on the financial system. The total March 2020 expenditure on these codes is used to estimate an average salary. After adjusting agency costs for an average **25%** agency fee, the total expenditure has been divided by the average number of agency & bank staff used during the year.
- The median salary has been calculated as the middle salary if salaries were ranked in ascending order.
- The highest paid director's remuneration is based on their total remuneration which includes all salaries and allowances (including director's fee), bonus payments and other remuneration.
- Excluded from the median pay calculation are staff whom, due to the in year changes in their personal circumstances, resulted in an annualised salary lower than the national minimum wage and are therefore not considered indicative of a true annualised full time salary.
- Also excluded are the Chair and Non Executive Directors who are not classified as employees and do not have Whole Time Equivalent attached to their earnings.
- Southern Health performs a large proportion of its services in house, including facilities management. The Trust has however outsourced the majority of its cleaning and laundry services; this may affect the comparability of the ratio to other NHS organisations who may have followed alternative outsourcing solutions.
- The median pay has increased to **£30.7k** from **£29.6k** mainly due the average Agenda for Change pay award uplift, a richer permanent staff mix plus a greater quantity and richer staff mix of Agency staff.

- Final summary 2018/19:

Name and title	2018/19					
	Salary £ 000's (bands of £5,000)	Taxable Benefits £'s (to the nearest £100)	Annual Performance-related Bonuses £ 000's (bands of £5,000)	Long-term Performance-related Bonuses £ 000's (bands of £5,000)	Pension Related Benefits Restated £ 000's (bands of £2,500)	Aggregate £ 000's (bands of £5,000)
Chair and Non-Executive Directors						
Lynne Hunt[2]	55–60	6,000	0	0	0	65–70
Jennifer Bremner	10–15	2,200	0	0	0	15–20
Dr David Hicks	10–15	2,000	0	0	0	15–20
David Kelham	10–15	3,500	0	0	0	15–20
David Monk	10–15	0	0	0	0	10–15
Robert Goldsmith	5–10	500	0	0	0	5–10
Malcolm Berryman[3]	0	200	0	0	0	0–5
Judith Smyth[3]	0	200	0	0	0	0–5
Trevor Spires[3]	0	200	0	0	0	0–5
Executive Directors						
Dr Nick Broughton[4,6]	200–205	1,300	0	0	165–167.5	365–370
Paula Anderson[6]	130–135	1,600	0	0	32.5–35	165–170
Dr Sarah Constantine[1,5]	0–5	0	0	0	0	0–5
Julie Dawes[5]	60–65	500	0	0	0	60–65
Paul Draycott	105–110	1,100	0	0	0	105–110
Paula Hull[1,6]	110–115	900	0	0	85–87.5	200–205
Dr Karl Marlowe[5,6,7]	160–165	8,300	0	0	0	170–175
Barry Day	80–85	4,400	0	0	0	85–90
Debbie Robinson[1,6]	5–10	100	0	0	67.5–70	75–80
Mark Morgan	20–25	3,800	0	0	0	20–25

1.These officers all worked for the Trust in capacities other than as members of the Trust Board during the financial year, associated non-board earnings have not been shown in the table but are declared as follows: Sarah Constantine 2018/19 £135–£140k, Paula Hull 2018/19 £0–£5k, Debbie Robinson 2018/19 £75–£80k.

2. The amounts disclosed within taxable benefits for this officer include tax and national insurance contributions paid by the Trust for home to work travel benefit covered by a PAYE Settlement Agreement (PSA) with the HMRC.

3. The amounts disclosed within taxable benefits for these officers relate to 2017/18 PAYE Settlement Agreement (PSA) with the HMRC paid in 2018/19 per the filing deadlines.

4. Dr Nick Broughton re-joined the NHS Superannuation scheme in 2018/19, back dated to his commencement with the Trust 6 November 2017 so the change in year covers a 17 month period.

5. Pension related benefits have resulted in a negative change, in compliance with reporting regulations this is represented with zero value.

6. The pension related benefits have been restated following the issuance of clearer guidance regarding their calculation. Originally stated were Dr Nick Broughton £200k–£202.5k, Paula Anderson £50k–£52.5k, Paula Hull £105k–£107.5k, Dr Karl Marlowe £7.5k–£10k, Debbie Robinson £75k–£77.5k.

7. Dr Karl Marlowe's remuneration includes the allocation of two clinical programmed activities related to his clinical role 2018/19 £25k–£30k.

The pension related benefits have been restated following the issuance of clearer guidance regarding their calculation.

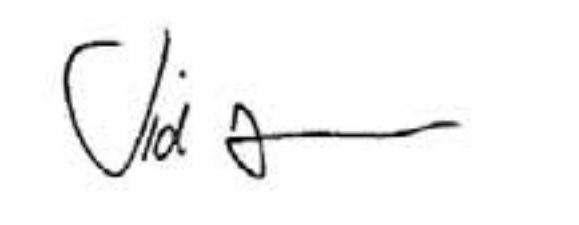
Payments for loss of office

The Trust has not made any payments for loss of office in 2019/20 or 2018/19.

Payment to past Senior Managers

The Trust has not made any payment of money or any other assets, to any individual who was not a Senior Manager during the financial year, but had previously been a Senior Manager of the Trust at any time.

Signed:



Dr Nick Broughton, Chief Executive

2 June 2020

2.3 STAFF REPORT

As at 31 March 2020, the Board of Directors consisted of seven Executive Directors (four male and three female) and eight Non-Executive Directors (five male and three female).

As at 31 March 2020, excluding Executive Directors, the Trust had **6,067** employees (**1,013** male and **5,054** female.) This does not include agency staff. The Whole Time Equivalent number of staff is **5,480**.

Information about our Gender Pay Gap including our latest report is available on our website: https://www.southernhealth.nhs.uk/about/equality-and-diversity/equality-and-diversity-reports/

Definition of Senior Managers

For the purpose of this report we define Senior Managers as Executive Directors (with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and the requirements of the post), and other Senior Managers with board level responsibility.

Staff costs - this information is subject to audit

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the Annual Report instead.

	Permanent £ 000's	Other £ 000's	2019/20 Total £ 000's	2018/19 Total £ 000's
Salaries and wages	167,779	4,920	**172,699**	166,783
Social security costs	16,438	–	**16,438**	15,896
Apprenticeship levy	841	–	**841**	812
Employer's contributions to NHS pension scheme	31,799	–	**31,799**	21,422
Pension cost – other	62	–	**62**	27
Termination benefits	–	59	**59**	633
Temporary staff	–	26,802	**26,802**	20,117
Total gross staff costs	**216,919**	**31,781**	**248,700**	**225,690**
Recoveries in respect of seconded staff	–	–	–	–
Total staff costs	**216,919**	**31,781**	**248,700**	**225,690**
Of which: Costs capitalised as part of assets	957	116	**1,073**	**1,174**

Average number of employees (WTE) - this information is subject to audit

	Permanent number	Other number	2019/20 Total number	2018/19 Total number
Medical and dental	220	31	**251**	254
Administration and estates	1,336	24	**1,360**	1,365
Healthcare assistants and other support staff	1,279	236	**1,515**	1,473
Nursing, midwifery and health visiting staff	1,652	142	**1,794**	1,729
Scientific, therapeutic and technical staff	540	20	**560**	538
Total average numbers	**5,027**	**453**	**5,480**	**5,359**
Of which: Number of employees (WTE) engaged on capital projects	15	2	**17**	**25**

Reporting of compensation schemes – exit packages 2019/20 - this information is subject to audit

The Trust made one compulsory redundancy in 2019/20; this was a consequence of the conclusion of a Trust wide Senior Leadership Change Programme that had begun in January 2019. Whilst this change programme had been one of the largest projects the Trust had undertaken for some time, this was delivered with only one member of staff unable to be suitably redeployed, out of the 30 directly affected.

The number of non-compulsory exit packages was significantly reduced from the previous year, this is mostly reflective of fewer staff making successful applications to exit employment under the mutually agreed resignation scheme.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	–	19	**19**
£10,000–£25,000	1	1	**2**
£25,001–£50,000	–	3	**3**
£50,001–£100,000	–	–	–
£100,001–£150,000	–	–	–
£150,001–£200,000	1	–	**1**
>£200,000	–	–	–
Total number of exit packages by type	**2**	**23**	**25**
Total cost (£)	**£172,000**	**£193,000**	**£365,000**

Reporting of compensation schemes – exit packages 2018/19

This information is subject to audit.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	–	28	28
£10,000–£25,000	–	5	5
£25,001–£50,000	–	7	7
£50,001–£100,000	–	1	1
£100,001–£150,000	1	–	1
£150,001–£200,000	–	–	–
>£200,000	–	–	–
Total number of exit packages by type	**1**	**41**	**42**
Total cost (£)	**£135,000**	**£498,000**	**£633,000**

Exit packages: Non-compulsory departure payments

We are required to publish our use of exit packages during the year, with comparative tables for the previous year. The following table details a number of exit packages used during 2019/20 and the table below give the comparative for 2018/19.

This information is subject to audit.

	2019/20		2018/19	
	Payments agreed Number	Total value of agreements £ 000's	Payments agreed Number	Total value of agreements £ 000's
Voluntary redundancies including early retirement contractual costs	–	–	–	–
Mutually agreed resignations (MARS) contractual costs	3	63	16	383
Early retirements in the efficiency of the service contractual costs	–	–	–	–
Contractual payments in lieu of notice	20	130	25	115
Exit payments following Employment Tribunals or court orders	–	–	–	–
Non-contractual payments requiring HMT approval	–	–	–	–
Total	**23**	**193**	**41**	**498**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	–	–	–	–

Expenditure on consultancy

During 2019/20 the Trust spent **£59,000** on consultancy support compared to **£110,000** in 2018/19.

Health and well-being of staff

Information on the health and well-being (including sickness absence data) of our staff can be found on the following website:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Our policy on off-payroll arrangements

We limit our use of off-payroll arrangements for highly paid staff. Staff engaged off-payroll for a duration of longer than six months during 2019/20 can be found in the following table. There were no Board members or senior members of staff with significant financial responsibility engaged in off payroll during the year.

Table 1: For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months:	
No. of existing engagements as of 31 March 2020	3
Of which : No. that have existed for less than one year at a time of reporting.	1
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	2
No. that have existed for between three and four years at time of reporting.	0
No. that existed for four or more years at time of reporting.	0
Confirmation that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Yes

Table 2: New off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months:	
No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020.	1
Of which : Number assessed as within the scope of IR35.	–
Number assessed as not within the scope of IR35.	1
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll.	0
Number of engagements reassessed for consistency/ assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review.	0

Table 3. Off-payroll engagements of board members, and/ or, senior officials with significant financial responsibility, between 1 April 2019 and March 2020:	
Number of off-payroll engagements of board members, and/ or, senior officials wth significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/ or senior officials with significant financial responsibility' during the financial year. (This figure includes both off-payroll and on payroll engagements).	8

Our approach to supporting staff with disabilities

Equality, Diversity and Inclusion is the responsibility of everyone in the Trust. The Equality Act 2010 places a statutory obligation on the Trust to protect the equality, diversity and inclusion of all its staff under nine protected characteristics, which includes disability. Southern Health is committed to actively recognising and promoting Inclusion and Diversity, by being a fair and supportive employer and treating staff with dignity and respect, challenging discrimination in all its forms and ensuring that equality lies at the heart of everything that we do. It is important that our disabled staff feel valued, and benefit from what diversity in the workforce brings.

These bullet points provide a roundup of our activity for the year 2019/20:

- *Inclusion Seminar with Paul Deemer, Head of Diversity and Inclusion at NHS Employers, May 2019:*
  Members of our VOX POP (A Vox Pop is an event where the Trust captures staff opinions on a particular topic) Network joined us to work through diversity and inclusion priorities, where a 21 point action plan was created. This plan has since been embedded into our People and Organisational Development Strategy which was refreshed in December 2019. The strategy has key elements focusing on the support we provide for disabled staff (discussed below).

- *Surviving the NHS Event, June 2019:*
  A stand was held at the University of Surrey for prospective employees which gave information about the services provided at Southern Health, including services for Disabled staff, VOX POP Networks and our Inclusion action plan.

- *Leadership Essentials, Management Essentials, Inclusive Leadership Course, June 2019:*
  We have included unconscious bias training in the existing Leadership essentials module (and has since been included in Certificate in management coaching and mentoring course).

- *Hoglands Mela & Southampton Caribbean festival, July 2019, PRIDE August 2019:*
  Stalls were held at these community festivals, where we discussed working with Southern Health and training and career development opportunities, including reaching out to members of the public with disabilities.

- *Disability Information Day, Stand at Basingstoke Shopping Centre, September 2019:*
  Featuring the Trusts Learning Disability team giving information on services, including career opportunities for people with disabilities. The local mayor was present at this event and it is a great opportunity to give the Trust coverage. Our applications from staff declaring a disability has increased from 707 in 2018 to 919 in 2019.

- *Nursing day conference stand, October 2019:*
  People development stand at this event for our mental health nurses which highlighted courses for staff and support available including those with disabilities.

- *Leading live Ally training, October 2019:*
  Training to staff on recognising ones privilege and becoming Allies in the workplace. Since this training, we have delivered a session to the board and they have also signed up to become Allies and received their badges.

- *Hate Crime Event, October 2019:*
  The event highlighted the importance of recognising Hate Crime and ways for staff to report it. Hampshire Police, Victim Support and Hampshire Hate Crime Network gave presentations, as well as a number of representatives from across the Trust such as our Freedom to Speak up Guardian.

- *Inclusion Board Seminar, November 2019:*
  The Board seminar included a session on exploring staff experience through the lens of Disability and Learning Difficulties. The session had members of our VOX POP Disability Network give information to the board on their challenges through lived experience of having a disability and a discussion from the board in regards to supporting staff with disabilities.

- *Romsey Disability Network and Southampton Hate Crime Network and Inclusion network meetings:*
  Regularly attending meetings with these community groups in order to strengthen our ties with the local disabled community and promote the services that Southern Health provides. Attendance at these meetings also includes discussions on strategic ways to promote inclusion and support for staff with disabilities.

Our VOX POP Staff Disability Network continues to grow and be a vibrant source of inclusion and diversity innovation. The network are kept up to date with our WDES (Workforce Disability Equality Standard) performance, staff survey results and actions plans from this data. An open forum is held to involve members in key discussions that effect disabled staff.

This year, Southern Health will launch the Disability Passport, which has been produced and co designed with VOX POP Staff Disability Network members. The procedure provides a framework for line managers and disabled staff to have discussions around their needs, ensuring that reasonable adjustments are made, and that disabled staff feel valued and respected. We remain accredited under the Disability Confident Scheme, which highlights our commitment around employment, retention, training and career development of disabled employees. The guaranteed interview scheme reassures applicants with disabilities that they will be interviewed if they meet the minimum criteria on the person specification.

The launch of the People and Organisational Development Strategy 2019–2024 emphasises the culture that we aspire the Trust to adopt. The Strategy includes equality of opportunity for promotion within the Trust, diverse interview panels and training for all staff regarding inclusion. We will also be reviewing the sickness policy to ensure that it includes provisions for disability and mental health. A relaunch of our equality standard within the new divisional structure and a clear pathway of employment for people with lived experience and learning disability will also enable processes to be fairer.

Priority People Projects help give focus to progressing key elements of our People and Organisational Development Strategy, the Workforce Directorate has chosen bullying and harassment as a key priority project, which will allow extra strategic focus and momentum towards inclusion in the workplace. From recruitment selection and throughout the employment lifecycle, we have policies to support the fair treatment and equal opportunities of all employees.

Monitoring performance is essential if we are to ensure that we are meeting the needs of our staff. Quarterly VOX POP meetings and monitoring the results of the annual Staff Survey will help us to determine outcomes for disabled staff.

We will continue to report annually on the WDES, a set of ten specific measures, which will enable us to compare the experiences of disabled and non-disabled staff. The information will enable us to assess our performance and develop further plans by understanding the experience of disabled staff. Equality Impact Assessments are continued to be completed when a Trust policy is reviewed and assesses the impact of the policy on disabled staff. The Trust will continue to undertake a full analysis of workforce data by using the protected characteristic, and address any gaps in reporting.

How does the Trust consult with staff?

We have two formal forums through which we inform and consult staff on a regular basis. Our consultative and negotiating arrangements take the form of a Local Negotiating Committee (LNC) (for medical and dental staff) and Joint Consultative & Negotiating Committee (JCNC) (for all other staff).

The JCNC acts as the main consultative body and provides regular consultation, information exchange and discussion between the Trust and the Trade Unions to maintain and improve management/ staff relations. Meetings are normally held bi-monthly.

Since April 2019 the JCNC has convened on five occasions; May 2019, July 2019, November 2019, January 2020 and March 2020.

The LNC is a sub-committee of the JCNC with agreed powers to reach settlements, which are subsequently reported to the full JCNC. The committee is also the forum through which the Trust will consult with medical staff on relevant matters including service change which may have an impact on medical and dental staff.

How does the Trust inform staff?

We use a range of different methods to ensure our staff are informed of matters relating to them.

These include:

- **Weekly Bulletin** – Trust-wide email newsletter sent to every member of staff
- **All staff emails** – Covering high profile and urgent topics
- **CEO fortnightly blog** – Hearing the views of our Chief Executive on current topics
- **Director of Nursing and AHP blog** – A monthly blog sent to nursing and AHP staff on professional matters
- **Intranet news** – Updated daily with the latest news
- **Senior manager information cascade**.

We have also grown the use of our social media platforms with increasing numbers of staff following the Trust on our different channels including Facebook, Instagram, Twitter and YouTube. We have set up a dedicated Twitter feed for Southern Health staff, which contains information relevant to staff only.

Health and Safety

The Trust is committed to continuous improvement in health and safety and has developed standards and safety systems to achieve this. The Health and Safety management system includes the key elements of the Health and Safety Executive's (HSE) guidance document HSG65 'Managing for Health and Safety' acting as a best practise guide throughout the Trust.

This year we focussed on improving staff wellbeing, risk assessment compliance, our environments and learning from our incidents. Health and safety performance features at each and every division senior management team meeting aiding the open and honest conversations about safety. This has further been strengthened through partnership working and sharing good practice with neighbouring Trusts, staff and patients.

The Health and Safety Team carried out a programme of annual workplace inspections at each of our inpatient sites, to enhance the existing checks already in place. The aim of workplace health and safety inspections is to prevent work related accidents and ill health by identifying hazards and risk and ensuring compliance. The process also checks that preventative and protective control measures are working providing recommendations for improvement of our sites and management of health and safety. The Health and Safety Forum (Committee) continues to be held quarterly, progressing objectives and action plans, overdue risks and risk actions and incident statistics are standing agenda items. Reports from subject matter experts including Estates and Facilities are included.

The safety of service users, staff and others continues to be a Trust priority and promotion of a positive safety culture will continue to be a key focus.

Counter Fraud

Our Counter Fraud Service is provided by TIAA who we work in partnership with to ensure there are appropriate measures in place to counter fraud, bribery and corruption in accordance with the NHS Counter Fraud Authority's (CFA) Standards for Providers. Our aim is to ensure NHS resources are protected against fraud and used for their intended purpose, the delivery of patient care.

TIAA's role is to ensure counter fraud measures are embedded at all levels across the organisation in line with the NHS CFA's strategy, to raise awareness amongst staff of fraud risks and potential consequences using a multi-media approach, and to ensure the reporting procedure is clear across the Trust.

TIAA also undertake preventative work to ensure opportunities for fraud are minimised by undertaking proactive reviews, and to professionally investigate referrals as they arise, in line with the sanction and redress principles of the NHS CFA.

All work undertaken by TIAA is overseen by our Finance Director and the Audit, Risk & Assurance Committee. The Anti-Fraud, Bribery and Corruption Policy was updated in July 2019.

Trade Union activity time

- Relevant union officials:

Number of employees who were relevant union officials during this period	Full time equivalent employee number
6	3.60

- Percentage of time spent on facility time:

Percentage of time	Number of employees
0%	/
1–50%	3
51–99%	/
100%	3

- Percentage of pay bill spent on facility time:

Total cost of facility time	Total pay bill	Percentage of the total pay bill spent on facility time
£30,175.17	£248,700,000	0.01%

- Paid trade union activities:

Hours spent on paid facility time	Hours spent on paid trade union activities	Percentage of total paid facility time hours spent on paid TU activities
1796	464	25.84%

Facility Time is the provision of paid or unpaid time off from an employee's normal role to undertake duties and activities as a trade union representative. There is a statutory entitlement to reasonable paid time off for undertaking union duties; however, there is no such entitlement to paid time off for undertaking union activities.

Trade union duties include:

- negotiations in respect of pay/ terms & conditions of employment
- negotiation and development of HR practices/ policies
- undertaking job grading/ evaluation
- attending to matters of discipline & grievance etc
- promoting effective communication between union representatives and members in the workplace.

Trade union activities include:

- attending workplace meetings to discuss and vote on the outcome of negotiations with the employer
- meeting with full time officers
- attending branch, area or regional meetings of the union
- attending meetings of official policy making bodies such as the executive committee or annual conference.

Our commitment to staff engagement

We are working to create a culture where compassionate and collective leadership is seen as everyone's business regardless of where or in what capacity they work; where there is a culture of inclusivity and this is not just spoken about but actually seen and felt across the organisation; a culture where people are enabled to achieve, be heard and express their ideas and innovation for the continuous improvement of the care we provide. Our way of working is articulated best within our people and organisational development strategy 2019–24, which highlights how we wish our staff to experience staff engagement:

"I feel the Trust listens to my team, involving us all in decisions which impact our service and our patients. My team feels pride, advocating for Southern Health to our patients, colleagues and partners. Our team contribution is recognised and rewarded by our division and the wider Trust. My team feels motivated, energised and proactive. My team is aware of its culture and we take steps together to improve it. We understand the interdependencies with other teams internally and externally, in delivering great care."

Our priority is all about increasing staff engagement. There is a wealth of evidence that when staff are engaged and involved in decisions, the outcomes for their patients, their performance and motivation improves.

How we measure staff engagement?

Staff engagement is measured biannually, once in the autumn through the NHS Staff Survey, again in the spring through our own internally developed and managed Cultural Insights survey and quarterly through the Friends and Family Test. It can also be measured on request for a specific team or group of staff that work together using a bespoke version of the survey.

Feedback from surveys is shared with all staff through staff bulletins and through our analytics system, Tableau. In addition to reporting of themes, trends, performance against ourselves and sector, we feedback cultural performance to teams through discussing the relative health of 10 key working conditions conducive to a happy culture, as well as the eight measurable associated behaviours that arise from a healthy working environment.

Our tableau culture database is growing and for some teams the addition of the 2019 staff survey data will mean they have four culture data sets, enabling them to monitor cultural and engagement performance over time. The measure of staff engagement within the Trust remains stable at **67%**.

We also use this information to identify teams that are high performing, either those that have achieved a high engagement score or those that have significantly improved. These teams receive a congratulatory letter from the Executive Director of Worforce, Organisational Development and Communications sent by Divisional Directors and we learn from and share their best practice through our Team Development and Leadership programmes.

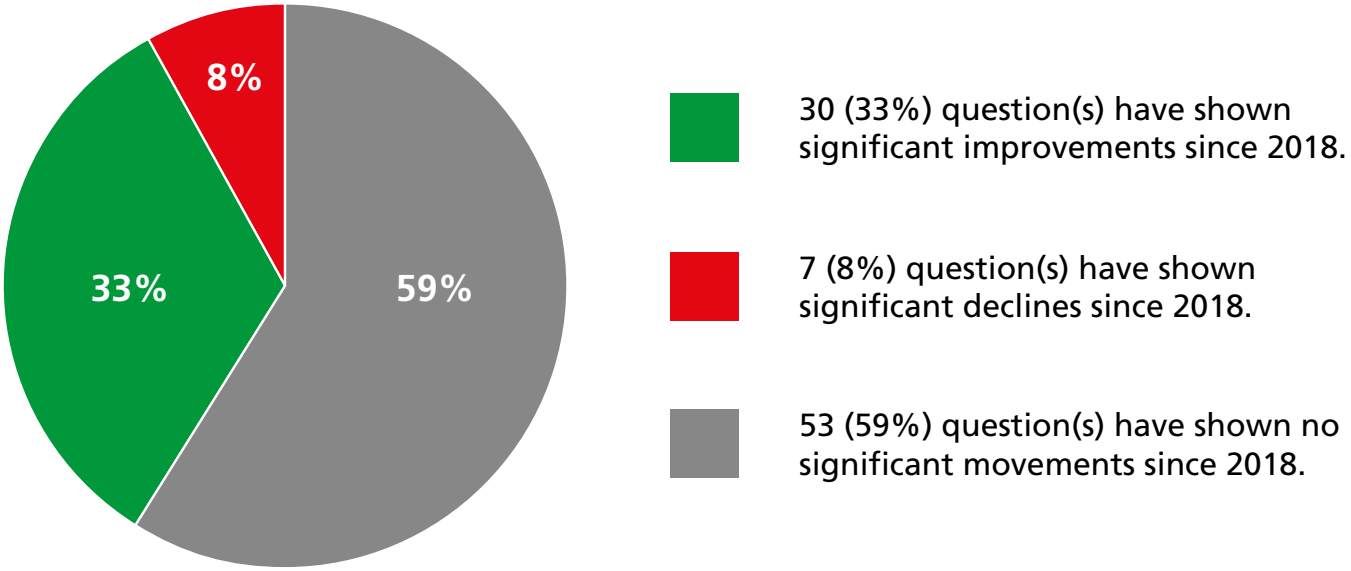
Low scoring teams (below our average of **67%**), or those that are on a downward trajectory are also identified. Each of these team leaders is sensitively offered the opportunity to work with our People Development team to develop an evidence based team development programme targeted at the areas of lowest performance to improve engagement. Teams who have engaged with our bespoke programme have an average engagement improvement of **3%**, the highest being **16%**.

Staff survey

OUR 2019 NHS STAFF SURVEY RESULTS

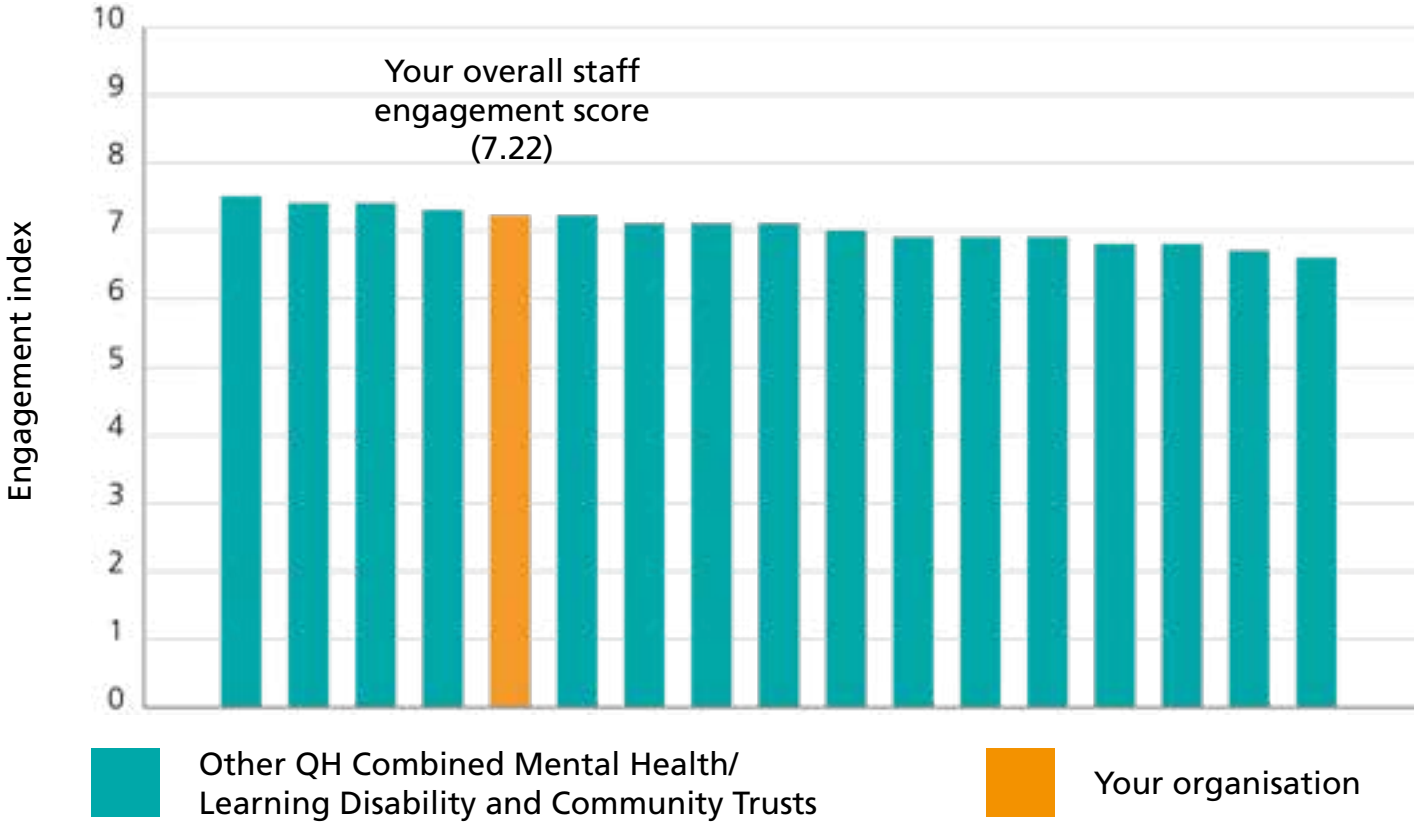
The results of the 2019 NHS Staff Survey indicate a positive picture with **2520** questionnaire responses, representing a response rate of **43.4%**.

At a question level, 33 questions are significantly better than the average for Combined Mental Health/ Learning Disability Trusts, and only 7 are significantly worse. Furthermore, we have 25 questions in the top **20%** range of scores and only 6 in the lower **20%** range. A lot of the best-performing questions are around the theme of staff engagement. The chart below shows the proportion of significant improvements/ declines compared to 2018 at question level.



Specifically on the theme of staff engagement our score in 2019 is 7.22 out of 10, meaning we rank in the top quartile of our comparator group and this score is improved against 2018 scores of 7.09.

The sub-section scores of advocacy, motivation and involvement have all improved slightly in the last year. Some question-level scores have improved, and almost all questions are in the upper-**20%** range of scores.



Theme	Staff engagement scores		
Overall staff engagement	2018	7.10	+0.11 (not sig.)
	2019	7.22	
Advocacy	2018	6.89	+0.12 (not sig.)
	2019	7.01	
Motivation	2018	7.38	+0.06 (not sig.)
	2019	7.45	
Involvement	2018	7.04	+0.13 (not sig.)
	2019	7.17	

Across the other themes in the staff survey:

- every question is better than the benchmark for equality, diversity and inclusion
- flexible working has significantly improved
- every question relating to relations with immediate managers has improved
- morale scores are better than or in line with sector averages as are those associated with quality of appraisals
- questions relating to quality of care have improved with the exception of feeling that roles make a difference to patients, which whilst improved, are currently lower than the sector average
- bullying and harassment is in line with the sector however, staff reporting this the last time this occurred has reduced in year
- job satisfaction is in line with the sector.

Score for the Trust against each of the 10 themes

A summary of 10 themes performance from 2017 to 2019 features in the table below:

	2019/20		2018/19		2017/18	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	9.12	9.12	9.2	9.2	9.3	9.2
Health and wellbeing	6.32	6.21	6.2	6.1	6.1	6.1
Immediate managers	7.44	7.32	7.3	7.2	7.3	7.1
Morale	6.39	6.31	6.2	6.2	No data available	
Quality of appraisals	5.62	5.64	5.6	5.5	5.4	5.4
Quality of care	7.38	7.44	7.2	7.4	7.2	7.4
Safe environment – bullying and Harassment	8.23	8.26	8.1	8.2	8.2	8.3
Safe environment – violence	9.52	9.47	9.5	9.5	9.5	9.5
Safety culture	6.92	6.84	6.8	6.8	6.8	6.7
Staff engagement	7.22	7.09	7.1	7.0	7.0	7.0

- The top 10 of the most significantly improved questions are:

Number	Question	Change
22c	Feedback from patients/ service users is used to make informed decisions within my Directorate/ Department	+6.51
4e	I am able to meet all the conflicting demands on my time at work	+6.31
10c	On average, how many additional UNPAID hours do you work per week for this organisation, over and above you contracted hours?	-5.89
4g	There are enough staff at this organisation for me to do my job properly	+5.74
16b	In the last month have you seen any errors, near misses or incidents that could have hurt patients/ service users	-5.74
17a	My organisation treats staff who are involved in an error, near miss or incident fairly	+5.62
4d	I am able to make improvements in my area of work	+ 4.80
5f	How satisfied are you with the opportunities for flexible working patterns?	+4.44
18c	I am confident that my organisation would address my concern	+4.15
23c	I often think about leaving this organisation	-3.99

- The seven significant declines:

Number	Question	Change
13d	The last time you experienced bullying and harassment at work did you report it?	-4.89%
14	Does your organisation act fairly with regards to career progression/ promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?	-3.94%
20	Have you had any learning or development in the last 12 months?	-3.40%
4i	The team I work in often meets to discuss the teams effectiveness	-2.86%
3b	I am trusted to do my job	-2.85%
16c	The last time you saw an error, near miss or incident that could have hurt staff or patients/ service users did you report it?	-2.33%
19a	In the last 12 months, have you had an appraisal, annual review, or KSF development review?	-2.17%

Action plans to address areas of concerns

The action plan for the 2019 Staff Survey results has seven areas of key focus:

1. All appraisals will contain a personal learning plan.
2. A new dedicated AHP/ Nursing Academy will be created.
3. Diverse interview panels will be piloted.
4. Team Cultural Insights conversations will take place in all teams.
5. 'It's not OK' Bullying and Harassment campaign will be launched with appropriate training.
6. Listening events with areas of services reporting lowest levels of materials to do the job so this can be best understood.
7. We will establish a process to Quality Improve our existing Bullying and Harassment reporting and support process.

Staff appraisals

We are committed to enabling managers and staff to get the best from their annual appraisal. Evidence tells us that when appraisal is conducted in the right way and for appropriate goals, it improves job satisfaction, employees' satisfaction, motivation to employees, and as a result the quality of working life (European Journal of Management, 2019). Research from the Kings Fund also tells us where we have high staff engagement, the better patient care provided. Therefore we maintain our commitment to improving our annual appraisal for all staff.

2019 appraisal progress

Our appraisal process will always be an evolving one – it's really important we continue to gather feedback on its effectiveness to ensure the process remains valuable, meaningful and people focused. We do this using our staff survey and our annual appraisal survey.

In 2018 we undertook our biggest appraisal review to date and collected feedback from 677 staff which has led to a number of changes. In 2019, we launched our revamped paperwork and our appraisal window will now run from 1 March to 31 July, which now enables staff more time to complete their appraisals. Our appraisal will still work on a cascade basis, starting with Executives in March.

Our Staff Survey data from 2018 and 2019 shows us where we're doing well, but still points to areas for improvement:

Staff Survey Measure 2019	Change in Year
Quality of appraisals	No change
It helped me to improve how I do my job	↓ 1%
It helped me agree clear objectives for my work	↓ 0.5%
It left me feeling that my work is valued by my organisation	↑ 0.8%
The values of my organisation were discussed as part of the appraisal process	↓ 1.1%
Were any training, learning or development needs identified?	↑ 1.8%
My manager supported me to receive this training, learning or development	↑ 3.3%
In the last 12 months, have you had an appraisal, annual review, or KSF development review?	↓ 2.2%

We are pleased to see that the quality of appraisal has remained the same in the 2019 Staff Survey. Improvements have been made in three areas, but there are also areas of opportunity.

Our plans for 2020

Linked to our Staff Survey 2019 results, we are committing to:

- improve our appraisal training to include how appraisal objectives can improve how staff do their job
- support managers and staff to set clear objectives together, ensuring these are linked to team, organisational and personal development goals
- increase awareness of the importance of discussing values within appraisal
- continue to thread our values and behaviours through our processes so that they are truly embedded within the organisation
- to continue the positive improvement made around managers supporting staff to access training, we will include a Personal Learning Plan within the appraisal template from March 2020
- People Development team will communicate a clear development offer for staff
- highlighting areas of good appraisal practice and showcasing the results of having good quality and supportive appraisals.

Supporting staff health and wellbeing

We believe that our staff must be at their best to provide the best care to our patients and service users. All our staff are encouraged to access our extensive health and wellbeing programmes should they need to. The NHS Staff Survey shows that 'NHS Trusts that score highly on the health and wellbeing index have better performance across a range of measures, including financial, spending on agency staff, patient satisfaction and fewer acute infections' (Personnel Today, 2018). Therefore we remain committed to further improving the health and wellbeing of staff and building on our support offer. Our way of working is articulated best within our People and Organisational Development Strategy 2019–24, which highlights how we wish staff to experience health and well-being:

"I feel the Trust listens to me and cares about my health and wellbeing. I feel healthier, happier and more resilient. I feel psychologically safe, more confident and able to manage my own health and wellbeing. I feel able to talk to my manager about things that concern me. I don't feel the need to come to work when I'm unwell. I feel supported by the Trust to work flexibly to achieve balance, and to pursue passions and volunteering beyond my job."

2019 progress

In 2019, we used staff feedback from our staff engagement events and a Health and Wellbeing (HWB) Champions toolkit was designed and issued. The toolkit embraces the principles of Positive Psychology and offers staff the opportunity to identify 'what we are doing well' and 'what needs to improve', specifically in regard to:

- feeling positive at work
- enabling authentic relationships at work
- developing meaning through our vision, values and priorities
- celebrating success and accomplishments.

HWB engagement and champion days were delivered across the Trust in 2019. These included mindfulness exercises, exercise taster sessions, massage and holistic therapies. We have also undertaken a baseline mapping in regard to NICE Standards on Health and Wellbeing Management and will be using this as an annual benchmark for improvement.

Our Occupational Health Services are provided by People Asset Management (PAM) OH Solutions. PAM OH Solutions are a highly experienced occupational health and wellbeing specialist providing a wide range of occupational health solutions. PAM offers:

- pre-employment health screening
- occupational health advice to support sickness absence management and wellbeing at work
- immunisations and screening
- sharps incidents and needle sticks helpline
- health/ workplace assessment (surveillance and screening).

We also offer fast-track services to talking therapies (IAPT), Recovery College courses, critical incident stress management, and fast-track MSK services. In addition, staff can access employee assistance services provided by Workplace Options who offer a range of wellbeing services including short term counselling.

We have recently received our 2019 Staff Survey results and we're delighted to see that our overall health and wellbeing score is above average when compared against other NHS organisations. The below table summarises our progress, including where we have made improvements and our areas of focus for 2020.

Staff Survey Measure 2019	Change in Year
Overall Health and Wellbeing	↑ 0.1%
The opportunities for flexible working patterns	↑ 4.6%
Does your organisation take positive action on health and well-being?	↑ 2.0%
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	No change
During the last 12 months have you felt unwell as a result of work related stress?	↑ 0.6%
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	↓ 3.2%

Our plans for 2020

We are taking the opportunity to review and evolve our HWB offer in 2020. By focusing explicitly on supporting staff wellbeing there are clear benefits to individual colleagues but also to the organisation and our patients in terms of improved retention and reduced sickness absence. This will include:

- consulting with staff to create a Trust-wide definition for 'health and wellbeing'
- asking staff what would improve their HWB, and what HWB means to them, which will enable us to create an offer which meets the needs of our staff
- designing and implementing a coordinated, accessible wellbeing offer
- full launch of our Vivup platform, our one-stop shop for HWB
- relaunching the quarterly HWB Group, with membership made up of those passionate about improving the HWB of staff
- mapping our HWB champions, to ensure we have the right resource across Hampshire who are able to signpost staff to support at a local level, and sharing list of champions within divisions
- providing bi-annual CPD (Continuous Professional Development) for HWB champions
- working closely with our Recovery College colleagues to create a wellbeing plan for staff and teams
- adding a new award category as part of our Star Awards, rewarding staff for taking positive steps to improving HWB in their teams.

Diversity and Inclusion

Diversity and inclusion are embedded in everything that we do. Our way of working is articulated best within our People and Organisational Development Strategy 2019–24, which highlights how we wish staff to experience an inclusive workplace:

"I feel accepted and valued for who I am. I feel supported by Allies at every level. I feel that there is equality of access to opportunities at Southern Health. I feel part of an organisation which does not tolerate harassment or discrimination. I feel the Trust is aware of subconscious bias and is proactively tackling this. I feel that the Trust truly recognises and celebrates diversity in all its forms. I feel part of an inclusive culture."

This past year has seen us increase our engagement with different local communities too, such as Southampton PRIDE, Southampton MELA, Caribbean community events, Disability Awareness Days and working closely with Chrysalis and Romsey Disability Network. After the success of our "How R U Today?" theme at Southampton PRIDE, reaching out to thousands of people through radio, local newspaper, social media and during the event itself, we have been asked to participate in Hampshire PRIDE and we will be carrying forward the same theme, with a different one at Southampton PRIDE.

The Trust also became proud champions of Stonewall and have recently received an appraisal of our Workplace Equality Index Submission, where recommendations have been made for us to take our work for LGBT+ staff and patients further. The Executive Director for Workforce, Organisational Development and Communications, Paul Draycott won Stonewall's Senior Champion for South Region Award, which recognises his visible commitment to the LGBT+ Inclusion network.

This year we have awarded a contract with an Interpretation and Signing partner, which will help user access to timely interpretation support, in a cost effective way.

The Workforce Race Equality Standard (WRES) and draft Workforce Disability Equality Standard (WDES) were presented at the Workforce & Organisational Development Committee. Both these papers outlined performance and high impact actions that have been designed and undertaken, key successes and plans for the future.

Our Staff Survey results relating to Inclusion

Staff Survey Measure 2019	Change in Year
Does the organisation act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability of age?	↓ 3.9%
In the last 12 months have you personally experienced discrimination at work from patients/ service users, their relatives or other members of the public?	↑ 1.3%
In the last 12 months have you personally experienced discrimination at work from manager/ team leader or other colleagues?	↑ 0.2%
Has your employer made adequate adjustment(s) to enable you to carry out your work?	↑ 2.2%

Staff Equality Network Groups

Our VoXPoP (Voice of the People) sessions for Disability, BAME and LGBT+ staff were launched last year and have been continuing every month, with attendees helping to shape both the content and implementation of our strategy.

In May 2019, an Inclusion Seminar was held, with Paul Deemer, Head of Diversity and Inclusion, NHS Employers was present and with our staff members we comprised a 21 point action plan which has then been built into the Trusts Inclusion strategy.

In November 2019, a Board seminar was held with a focus on equality and challenging the Board to identify ownership on areas identified for improvement from the annual NHS Staff Survey and Workforce Diversity Scorecard. VoXPoP staff shared powerful stories of experience to the board, which continues to shape thinking and reflection as well as leading to reverse mentoring relationships.

This year we have had also celebrated a series of events such as Interfaith week, Black History Month, LGBT+ month and Disability Awareness day.

2.4 COMPLIANCE WITH THE CODE OF GOVERNANCE

Southern Health 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 Code of Governance contains a number of statutory requirements, with which the Trust is compliant and do not require disclosure statements in the Annual Report.

Additionally, there are a number of other provisions that require the Trust to give a supporting explanation as to whether the Trust is compliant or not: in line with the guidance in the code, where this information is already contained within the Annual Report, a reference to its location is contained below:

Provision	Requirement	Reference in Annual Report/ response
A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of Governors. This statement should also describe how any disagreements between the council of Governors and the board of directors will be resolved. The Annual Report should include this schedule of matters or a summary statement of how the board of directors and the council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	This information is set out on pages 65, 66 and 75 of the Annual Report.
A.1.2	The Annual Report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	This information is set out on pages 57–64, 79 and 91 of the Annual Report.
A.5.3	The Annual Report should identify the members of the council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The Annual Report should also identify the nominated lead Governor.	This information is set out on pages 77-78 of the Annual Report.
B.1.1	The Board of Directors should identify in the Annual Report each Non-Executive Director it considers to be independent, with reasons where necessary.	This information is set out on page 64 of the Annual Report.

Provision	Requirement	Reference in Annual Report/ response
B.1.4	The Board of Directors should include in its Annual Report a description of each director's skills, expertise and experience. Alongside this, in the Annual Report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	This information is set out on pages 57–64 of the Annual Report.
B.2.10	A separate section of the Annual Report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Nomination & Remuneration Committee – This information is set out on page 91 of the Annual Report. Appointment Committee – This information is set out on page 78 of the Annual Report.
B.3.1	A chairperson's other significant commitments should be disclosed to the council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the council of Governors as they arise, and included in the next Annual Report.	The Chair has no other significant commitments to disclose.
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed Governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	This information is set out from page 75 of the Annual Report.
B.6.1	The Board of Directors should state in the Annual Report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	This information is set out on page 65 of the Annual Report.
B.6.2	Where there has been external evaluation of the board and/ or governance of the Trust, the external facilitator should be identified in the Annual Report and a statement made as to whether they have any other connection to the Trust.	This information is set out on page 65 of the Annual Report.

Provision	Requirement	Reference in Annual Report/ response
C.1.1	The directors should explain in the Annual Report their responsibility for preparing the Annual Report and Accounts, and state that they consider the Annual Report and Accounts, taken as a whole, 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. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	This information is set out on pages 84 of the Annual Report.
C.2.1	The Annual Report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	This information is set out on pages 125 and 136 of the Annual Report.
C.2.2	A Trust should disclose in the Annual Report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	This information is set out on pages 66–67 of the Annual Report.
C.3.5	If the council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the Annual Report a statement from the audit committee explaining the recommendation and should set out reasons why the council of Governors has taken a different position.	N/A
C.3.9	A separate section of the Annual Report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	This information is set out on pages 66–67 of the Annual Report.
D.1.3	Where an NHS Foundation Trust releases an executive director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the Annual Report should include a statement of whether or not the director will retain such earnings.	N/A

Provision	Requirement	Reference in Annual Report/ response
E.1.4	Contact procedures for members who wish to communicate with Governors and/ or directors should be made clearly available to members on the NHS Foundation Trust's website.	This information is set out on page 75 of the Annual Report.
E.1.5	The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about the NHS Foundation Trust, for example through attendance at meetings of the council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	This information is set out on pages 74 and 78 of the Annual Report.
E.1.6	The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the Annual Report.	This information is set out on pages 73–74 of the Annual Report.

2.5 NHS OVERSIGHT FRAMEWORK

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

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (Well-led).

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

Segmentation

Southern Health NHS Foundation Trust has been placed in segment 3 which is defined as "Mandated and targeted support: support need identified in Quality of care"

This segmentation is the Foundation Trust's position as of March 2020. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England and NHS Improvement website.

Finance and use of resources

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

		2019/20				2018/19			
	Weight	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Capital service cover rating	20%	3	3	4	4	4	2	4	4
Liquidity rating	20%	3	3	3	2	2	1	1	1
I&E margin rating	20%	4	4	4	4	4	3	4	4
I&E margin: distance from financial plan	20%	3	1	1	1	4	1	1	1
Agency rating	20%	4	4	4	4	3	3	3	2
Risk ratings after overrides		3	3	3	3	3	2	3	3

Any rating with a score of 4 triggers an override of 3 for the overall rating

2.6 STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF SOUTHERN HEALTH 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 Southern Health 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 Southern Health 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 Group Accounting Manual and in particular to:

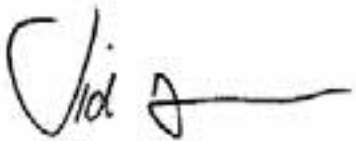
- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *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 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.

Signed:



Dr Nick Broughton, Chief Executive

2 June 2020

2.7 ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

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

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 Southern Health 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 Southern Health 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

The Foundation Trust has in place a Board approved Risk Management Strategy; this sets out the responsibilities of the Board in relation to the effective management of risk and compliance with relevant legislation.

As Chief Executive I have responsibility for maintaining a sound system of internal control and assurance that supports the achievement of the organisation's objectives and for risk management across the Foundation Trust.

I discharge these duties through the executive and management team, with clear designation of accountability to individuals to support me in this role. Responsibility for specific areas of risk is delegated to Executive Directors in line with functional roles, as well as formal designation of executive leads for specific roles. Within the clinical and corporate services, senior managers are responsible for ensuring they, and their staff, fulfil their responsibility for risk management by operating in accordance with the Foundation Trust systems, policies and procedures.

The Executive Management Committee ensures effective risk management by maintaining a dynamic Board Assurance Framework and Risk Register through which the Board can monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality. The Board Assurance Framework is aligned to our strategic priorities. The Committee purpose and membership was reviewed in 2019/20. The Committee meets monthly and reviews all risks that are exceeding the Foundation Trust's stated risk tolerance threshold.

The Audit, Risk and Assurance Committee is responsible for scrutinising the internal controls of the organisation including through regular review of the Board Assurance Framework, in order that the Board may place reliance on it. As set out in the Annual Report, membership of this Committee is limited to independent Non-Executive Directors, with Executive Directors and officers of Southern Health in attendance as required. Other Board Committees have responsibility for scrutinising and monitoring relevant risks, relevant sections of the Board Assurance Framework, and internal controls. The Audit, Risk & Assurance Committee routinely receives reports from all Board Committees which have regular oversight for specific areas of the Board Assurance Framework.

Risk management training is available to all staff as part of the Governance e-learning course. The Risk Management Strategy requires all staff to take responsibility for identifying and managing risk, regardless of their role. Targeted training is delivered to line managers, bands 6 and above, as part of the introduction to line management course. Appropriate training is also given to individuals with specific responsibilities for risk management. Copies of the Risk Management Strategy and Policy are available on the intranet and website. Work is underway to review and enhance the structure and content of risk management training in line with recommendations made in the Risk Maturity audit undertaken by BDO in year.

The risk and control framework

The Foundation Trust's risk management framework is set out in a number of key policy documents, including the Risk Management Strategy and Policy, the Board Assurance Framework Standard Operating Procedure and the Risk Appetite Statement. These documents provide a structured process for the identification, communication, assessment, escalation and management of risks. The Board Risk Appetite Statement defines boundaries and risk tolerance thresholds to support the delivery of our objectives, clearly defining the amount and type of risk that the Foundation Trust is prepared to seek, accept or tolerate.

The Board owns and manages a number of strategic risks, articulated in the Foundation Trust's Board Assurance Framework. In 2019/20 work commenced to further strengthen the alignment of risks with the Foundation Trust's strategic objectives, and to ensure there is a clear process whereby the Board is sighted on risks from the risk register through improved alignment between this and the Board Assurance Framework. Processes are responsive to changing circumstances and emerging issues of significance. The Board dedicated time during a seminar session in March 2020 to review the Risk Appetite Statement; this work will be taken forward in 2020/21. At this seminar the Board also agreed to directly align the strategic risks articulated within the BAF to each of the four strategic objectives, reducing the number of overarching strategic risks to four, providing a direct correlation with each of the strategic objectives; this work would be taken forward in 2020/21.

The discipline of risk management is embedded throughout the organisation, is a focus of internal audit, and forms a core element of divisional governance meetings, Trust-wide quality groups, board committees, and the Board. Public engagement is sought through service user representation at Trust-wide quality groups, and discussion at the Board. Key strategy and policy documentation for risk is signed off by the Board. Risk identification and management forms part of the divisional objective setting exercises, and is considered when drafting new strategy and policy documentation.

The Foundation Trust empowers and encourages all staff to identify, report, and manage operational risks; supported by an electronic risk management system. Staff are guided in articulating risk information through policy documentation and training. Staff are required to describe a risk in terms of cause and effect, and identify appropriate controls and assurances. Where control or assurance gaps exist staff are required to identify actions to address these gaps and to assign appropriate timescales and ownership to individual actions. Finally, staff are required to attribute an inherent, current, and target risk score to allow the Foundation Trust to prioritise risks based on impact and severity.

The Board has articulated scoring criteria based on the National Patient Safety Agency risk matrix, which is provided to help staff assess and prioritise risk. Risks are assigned three scores; inherent, (i.e. in the absence of an effective control framework), current (i.e. with controls in place) and target. A timeframe to meet the target score is required to encourage the pro-active management and eventual closure of identified risks.

Individual strategic risks have designated Executive Directors as owners, and control and assurance information is monitored by the relevant Board committee. The principal risks, as described on the Board Assurance Framework at the end of the year are set out below. The Foundation Trust uses a 5x5 matrix to rate risks where our score is attributed to the impact and to the likelihood of the risk, to give an overall rating.

Strategic Priority	Strategic Risk
Improve health and wellbeing through outstanding services	SR1: There is a risk that we fail to provide high quality or effective care, resulting in serious harm.
	SR2: There is a risk that we fail to continually improve the services provided by the Trust to deliver better outcomes.
	SR3: There is a risk we fail to provide patients with a positive experience of our services due to lack of meaningful engagement.
	SR4: There is a risk that we fail to maintain and develop confidence in Southern Health as a care provider.
	SR5: There is a risk that we do not maintain & develop Specialised Services in a way that benefits patients.
Become the best employer	SR6: There is a risk that we cannot retain and attract sufficient and skilled staff.
	SR7: There is a risk that we fail to develop and maintain our culture in line with Trust values, and to support the delivery of outstanding services.
Transform services through integration and sustainable partnerships	SR9: There is a risk that we fail to provide good governance which prevents effective decision making.
	SR10: There is a risk that we fail to deliver integrated services.
	SR11: There is a risk that the quality of clinical care is affected as a result of poorly managed organisational change.
Improve value	SR8: There is a risk that we fail to deliver medium & long-term financial sustainability.

Details of the control frameworks for each strategic risk, assurances against controls, and actions to address gaps are detailed in each report made to the Board, available via the Trust's internet page.

Specifically, in response to the COVID-19 pandemic, a series of Trust-wide risks were identified; these are being monitored via the newly established COVID-19 Quality Assurance Committee, which is an adjunct to the standing Quality & Safety Committee.

The key risks identified in relation to COVID-19 that are outside the Trust's stated risk appetite are:

- There is a risk that the proliferation of the COVID-19 (Corona virus) will impact on the ability of the Trust to deliver core services
- There is a risk of insufficient staff supply due to high staff absence due to sickness/ self-isolation as a result of COVID-19 and additional demand for staff to open new beds which could impact on the Trust's ability to deliver both existing core services and additional bedded capacity
- There is a risk of insufficient Personal Protective Equipment of the right quality being available because of national supply chain issues which could impact on the Trust's ability to deliver core services in response to COVID-19
- There is a risk of clinical errors arising because of redeployment of staff to alternative roles, utilisation of unqualified staff, reduced clinical supervisions and reduced induction into new teams as a result of COVID-19, which could result in patients receiving adverse care
- There is a risk that staff do not use Personal Protective Equipment/ appropriately due to insufficient training, availability of equipment, or lack of awareness as to appropriate use which could result in staff becoming exposed to/ infected by COVID-19
- There is a risk that actions are taken outside of normal regulatory and legal frameworks due to unprecedented demand arising from COVID-19 impacting on normal business processes which could result in the Trust acting outside of usual best practice/ regulations
- There is a risk of psychological harm to staff because of the COVID-19 pandemic which could result in long-term harm or potentially death
- There is a risk of physical harm to staff because of the COVID-19 pandemic which could result in long-term harm or potentially death

The Trust has become increasingly dependent on the use of IT services to provide safe care to its patients and to support the wider business functions. These IT services – which include infrastructure, systems, applications or data – are critical in providing clinical care and for the day-to-day operational and support activities of the organisation. The loss of confidentiality, integrity or availability of these services would have a significant impact on the Trust and would reduce its ability to provide effective services.

The Trust therefore has a duty to protect all IT systems and infrastructure against the ever-increasing threat of cyber-attack. Prevention and preparedness is critical to safeguard the operation of all Trust activities. The Trust has a good foundation of controls – including people, process and technology – and these are based on a number of frameworks, these include the NHS Digital's Data Security and Protection Toolkit (mandated to all NHS organisations), the National Cyber Security Centre's '10 steps to Cyber Security', Cyber Essentials Plus and the international standards ISO27001 and ISO9001. The Trust is currently compliant with the Data Security and Protection Toolkit with the most recent published submission to NHS Digital in March 2020. The Trust also holds ISO27001 and ISO9001 for the IT operations services and is accredited as Cyber Essentials Plus.

The Trust is currently involved in a number of initiatives being offered by NHS Digital as part of the Cyber Security Support Model (CSSM) which was conceived following the widespread cyber-attack that impacted many other NHS organisations in 2017. This is designed to enable health and care organisations to identify, fix, embed and review cyber security to enhance their security posture. This has resulted in investment and external capability being available to the Trust; this has included support for onsite technical assessments, a briefing for the Trust Board on cyber security, the completion of an in-depth review of the Trust's overarching information risk framework and the facilitation of cyber-risk review workshop.

NHS Digital attended the Trust Board meeting in January 2020 and presented their assessment of the Trust's cyber security rating as 'low risk, high capability'. The Trust continuously works to develop capability and whilst we have not been subject to a successful cyber-attack we are not complacent.

In May 2019 a review of Board effectiveness against the Well-led framework was undertaken as part of the ongoing development of the Board, supported by TTI Development. The Well-led Framework supports providers to maintain and develop the effectiveness of their leadership and governance arrangements. The review included an observation of the Board in operation; this identified some positive ways of working including process, relationships and content against the Well-led Key Lines of Enquiry. Areas for further development were also identified; these were discussed by the Board at a seminar session in June 2019 as part of the ongoing programme of Board development.

The Trust's internal auditors, BDO, undertook an internal audit on strategic governance during summer 2019. This identified some areas to strengthen corporate governance arrangements within the Trust to support the Board in operating effectively.

In the CQC report published in January 2020, the Trust was rated as "Good" for Well-led; this was an improvement from the previous inspection where the Trust was scored as "Requires Improvement".

A full review of the Foundation Trust's compliance with the conditions of the NHS Provider licence is undertaken annually and reviewed by the Audit, Risk & Assurance Committee; this informs the Corporate Governance Statement, required by NHS Foundation Trust condition 4(8)(b), which is made annually by the Board.

In recent years the Foundation Trust has been subject to regulatory action and enforcement undertakings were submitted by the Foundation Trust and accepted by NHS Improvement in June 2018. The undertakings submitted seek to address the risks to compliance with those elements of licence condition FT4 (relating to Foundation Trust governance) where we have been found to be in breach.

Our self-certification submitted in June 2018 identified those areas where the Foundation Trust was found to be in breach of conditions of the licence, and subsequently, a declaration of "not confirmed" was issued on the pro forma for various elements of licence condition FT4. The Foundation Trust has continued to work to address the requirements set out in the enforcement undertakings, strengthening the governance and risk management arrangements in place in the organisation.

We have developed the risk management systems further to ensure that all identified risks are appropriately escalated to relevant decision-making groups, and that the Board and Committees are aware of relevant risks exceeding the expressed Trust risk appetite. Staff are able to access robust and appropriate information which supports their understanding of risk management processes.

A Strategy for Experience, Involvement and Partnership was developed and launched in 2017 with the involvement of patients, families, and the public. This sets out our commitment to work with people who use our services for involvement in their own care and treatment to ensure that they are routinely offered opportunities to participate meaningfully in the planning, delivery and monitoring of services. The strategy has been updated after engagement with a variety of stakeholder, service users and carers. Two key groups are also in place to further enable this:

- the Working in Partnership Committee – this monitors and reviews the programme of engagement for the Trust which includes the actions and recommendation following the CQC inspection
- the Carers, Families and Friends Group – which co-produced a carers programme of work which is aligned to the Joint Hampshire Strategy for Carers.

User involvement facilitators are also appointed to improve dialogue and involvement with carers and people using services and deliver greater co-production of improved services.

Stakeholder relationships are mapped and managed at strategic, Trust-wide, and local levels, aiming to develop open and transparent relationships where strengths and risks in services are shared and improved by working collaboratively. This includes early engagement and involvement where changes to and development of services are being considered, and close working with local authority Overview and Scrutiny Committees.

In November 2019 the Workforce & Organisational Development Committee and the Trust Board ratified a 'refreshed' People Strategy which outlines our ambition to 'Become the best employer', which is one of our key strategic priorities. A number of work programmes, milestones and targets were re-prioritised in response to the ever changing workforce context internally, system-wide and nationally. This will ensure that progress and delivery continues in a way that aligns to the Operational Plan and developing Workforce Plans as well as being sufficiently agile to respond to broader workforce challenges as they emerge.

The Strategy has been developed to support improved quality and safety of services for our communities, enabling the delivery of our Clinical Services Strategy and setting out the Trust Board's commitment to our people in making our organisation a great place to work.

The Strategy programmes also ensure that the Trust has relevant and up to date short, medium and long-term workforce strategies and staffing systems. During 2019 the Trust's five-year Workforce Plan has been developing well and is now informed by the local Divisional plans to ensure the right numbers, skill mix and competencies are planned to meet existing and future demand; these continue to be reviewed.

The final national Workforce Strategy is due later this year following consultation in 2018/19 setting out the challenges for the NHS for the next 10 years as part of the Long-Term Plan. It identifies six principles for us to meet locally and these have been woven into our People & Organisational Development Strategy.

Getting the right people, in the right place, at the right time, with the right skills is key to any successful enterprise and we are no different. There are supply challenges across the NHS at present and these need to be addressed directly or innovative solutions found which may include the use of digital solutions. Therefore a process of succession planning and enabling our people to fulfil their potential has to be implemented systematically across the Trust as does a competency framework to enable clear focus on development, education and recruitment.

We use a number of evidence-based safer staffing tools to monitor staffing levels across inpatient units, and community teams, applying professional judgement and clinical oversight to decision making around funded establishments. An electronic rostering system is in place across the wider Trust which provides a range of workforce data including the number and band of staff on a certain shift within the community or on the wards. This workforce data, along with shift fill and incident analysis is reviewed monthly by Executive Management.

The Trust has adopted the recommendations from 'Developing Workforce Safeguards' publication, with information reported to Board as required. The Board will receive the full annual summary of all the acuity and dependency measures in June 2020 (delayed from March 2020). In 2020/21 work will focus on strengthening and embedding Quality Impact Assessments for service changes, including skill-mix changes, and in advance of the redesign or introduction of new roles.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The CQC undertook a comprehensive inspection of four mental health core services of the Foundation Trust in October 2019; where the overall rating given improved from "Requires Improvement" to "Good". An improvement plan has been developed to address those areas of improvement highlighted in the report.

The Trust's assurance and validation process has been successful in ensuring the recommendations from previous CQC inspections are fully completed and embedded, demonstrated by the improved rating this year. This approach continues and progress against the improvement plan is reported to CQC during the Foundation Trust's quarterly provider engagement meeting.

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) 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 Foundation 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.

European Union (EU) Exit Preparedness

The UK left the EU on 31 January 2020 and is now in an 11 month transition period which is due to end on 31 December 2020.

The Trust continues to prepare for a wide range of scenarios across both nationally and locally identified risk areas including, supply chain (clinical and non-clinical consumables), staffing, research and development, data processing, finance and the potential for Portsea Island associated congestion. As part of these preparations, the Trust has put a significant amount of work into developing contingency plans to ensure the continuity of safe services to the people we support.

Over the coming months, the Trust will review these plans in light of any learning from both the local and national response to the COVID-19 pandemic and as the national EU Exit picture becomes clearer.

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

There are a number of key processes in place to ensure resources are used economically, efficiently and effectively. The Trust Board approves a business plan on an annual basis and detailed budgets are developed each year by division. The relevant Board committees are presented with the financial plan and budgets for both revenue and capital before final approval from the Trust Board.

The Foundation Trust invested **£18.8m** (including donated assets of **£825k**) in a range of capital projects in 2019/20. This included **£11.5m** for a major secure services development comprising a new learning disabilities residential unit which is due for completion in 2020 and a low-secure adolescent unit (Austen House) which was opened late summer 2019. The general capital programme of **£7.3m** covered projects for reducing ligature risks, improving health and safety, planned maintenance, new medical devices and investment in information technology.

During the year the Trust delivered savings of **£13.2m** (**3.9%** of the cost base) through a number of initiatives including service and workforce redesign, procurement and reduction of corporate overheads. However, it should also be noted that **£7.4m** (**56%**) of these savings were non-recurrent, which increases the financial challenge that the Trust will face during 2020/21.

Our long term strategic objectives are translated into specific annual actions and measures of success. These are given clearly defined metrics and targets that are monitored at Trust, divisional and team level. These measures include regulatory and commissioner defined targets. The Trust is also developing additional patient experience and outcome measures and feedback to enhance the range of performance information used.

The Performance Management and Accountability Framework is a key mechanism for ensuring the Trust's resources are focused on delivering high quality, well managed, safe and effective services. It describes the governance, reporting and performance management processes that operate within the Trust and how clinical and corporate divisions work together to ensure the Trust is able to clearly demonstrate that it is a high-performing organisation that is well governed and compliant with key indicators.

It has been designed to provide assurance to the Board, our stakeholders and regulators that the organisation is performing to the highest standards and has mechanisms in place to make changes where improvements are required and risks mitigated.

Oversight of performance is provided at each level (individual, team, division and Trust-wide) through regular reports and performance meetings, with a clear mechanism for escalation. At Trust Board and Committee level the Integrated Performance Report and subject-specific dashboards support decision making. Divisions and teams use Tableau reports to review performance daily and weekly; findings and actions are presented monthly to the Executive Performance Review which allows for Executive Director oversight on performance.

A key focus throughout this year has been to support the organisation to better understand and utilise data for effective decision-making. Information and analysis is used to identify risks and trends through performance management dashboards which incorporate quality and safety, finance, activity and workforce indicators. Statistical process control charts are used for the majority of indicators to provide early warning of a potential reduction, variation or improvement in performance and therefore progress against delivery of the Trusts overall strategic objectives.

We have a range of corporate governance and financial policies, including the Constitution and Standing Orders, Standing Financial Instructions, Scheme of Delegation and Board Reserved Powers in place.

There are also additional underpinning policies including those which describe our approach to effective procurement of goods and services. We use internal auditors to ensure compliance with these policies. Internal audit reports are shared with the Audit, Risk & Assurance Committee and any appropriate Board committees.

Internal Audit adopt a risk-based approach using the Foundation Trust's own risk management processes and risk register as a starting point for audit planning on the basis that this represents the Foundation Trust's own assessment of the risk to it achieving its strategic objectives.

Information governance

We have an established Information Governance Management Framework which continually works to identify and reduce risks to information and increase data security. The Foundation Trust has a nominated Caldicott Guardian (Deputy Chief Medical Officer), and Data Protection Officer (DPO)/ Senior Information Risk Owner (SIRO) (Director of Strategy and Infrastructure Transformation). The Foundation Trust's Information Governance Group, which is chaired by the Director of Strategy and Infrastructure Transformation, is responsible for ensuring compliance with the Data Security and Protection Toolkit (DSPT), which includes identifying and managing information risks and confidentiality breaches. The Foundation Trust has published its Data Security and Protection Toolkit for 2019/20 as "exceeded standards met".

There were five potential Level 2 confidentiality breaches in the financial year 2019/20 which were self-reported to the Information Commissioner's Office. The score is determined by the Foundation Trust's Information Governance Incident Reporting and Assessment Procedure, which is aligned to the NHS Digital national Information Governance Incident Reporting Tool. All were fully investigated internally, action plans developed and mitigations identified and implemented, and the information shared with the Information Commissioner's Office. All were closed by the Information Commissioner's Office with no further regulatory action.

There was one "concern" raised with the Information Commissioner's Office relating to the processing of a subject access request by the Foundation Trust; this was investigated and responded to and the Information Commissioner's Office confirmed that there was no further action required by the Foundation Trust.

Data quality and governance

In order to be assured of the quality of the data we supply to our stakeholders the Foundation Trust's Information Team have an agreed programme of Data Quality assurance audits. A sample of patient records is reviewed in line with the Standard Operating Procedures for recording completion of certain tasks that feed into the Key Performance Indicator reported. The audit programme includes all services within the Foundation Trust, including, but not limited to:

- Psychiatric Liaison
- Improved Access to Psychological Therapies.

This covers measures such as:

- 48-hour follow up
- Pressure ulcers
- Caseload accuracy.

Our validation of Referral to Treatment pathways is an ongoing process. Patient pathways are continuously reviewed, clocks are checked for accuracy and reporting enables monitoring of the current position against the national target. Booking teams, operational and clinical staff work closely together to ensure that what is best for the patient is central to the process.

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, the Audit, Risk & Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The following processes have informed my review of the effectiveness of our internal controls, as set out in this document.

The Board has reviewed the Board Assurance Framework and other performance and compliance reports. Assurance has been provided to the Board by the Audit, Risk & Assurance Committee and other Board Committees, with items formally escalated to the Board as required. The effectiveness of the system of internal control has been reviewed by the Audit, Risk & Assurance Committee, which has received the Board Assurance Framework as well as other reports, including those from Internal Audit, External Audit and Counter Fraud. The Committee receives all internal audit reports on both financial and non-financial areas and has monitored the implementation of all recommendations via follow up reports.

We have had a Clinical Audit Programme in place for 2019/20; performance against this plan was reported to the Quality & Safety Committee via the Clinical Effectiveness Group. The Clinical Audit Programme has been on track throughout the year and all audits have been delivered as per the programme. The Clinical Audit team have been working closely with the Foundation Trust's Transformation team to promote clinical audit as a tool for improvement; this has led to an increase in local audits being undertaken.

The Foundation Trust commissions a risk-based programme of assurance reviews from BDO, our internal auditors. Our Internal Audit Plan for 2019/20 was approved by the Audit, Risk & Assurance Committee, and 11 audits were undertaken during the year, with 7 finalised and 4 reaching a draft stage by year-end. Based on the work undertaken in 2019/20 we received the following Head of Internal Audit Opinion:

"Overall, we are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently. In forming our view we have taken into account that:

- The Trust's pre-audited financial outturn was reported as a total adverse variance against the revised control total of **£6.3m**. There were a number of technical adjustments which go into the accounts which were not considered as part of the control total; once these were included the deficit reduced to **£3.4m**.
- The majority of audits provided moderate or substantial assurance in the design of controls, including the key audit of key finance systems. Whilst a number had limited assurance for operational effectiveness, we were specifically directed by management to review these areas to help them improve the control environments.
- The Trust has a good record in implementing audit recommendations. We have closed all bar two prior year recommendations and management are proactive in discussing plans to address the risks identified in the 2019/20 audits.
- There are currently 4 remaining audits at draft report stage, however their outcomes will not change the overall audit opinion. These have not yet been finalised due to the operational impact of Covid-19 on the Trust."

Towards the end of 2019/2020, in response to the COVID-19 pandemic, the Foundation Trust implemented its business continuity arrangements. This has included changes to our usual governance arrangements, such as increased reliance on constitutional provisions to allow for decision-making outside of formal Board meetings, either through the exercise of emergency powers, or via written motions. The establishment of the COVID-19 Quality Assurance Committee and the Clinical Ethics Forum have also supported our governance arrangements to remain robust and responsive during these circumstances.

There are also a number of matters that require disclosure and serve to highlight where the Foundation Trust's system of internal control needs to be further strengthened. Action has been taken to address these issues in-year, as set out below:

◆ 2019/20 Control Total

The Foundation Trust's final, summarised financial position for 2019/20 was a control total deficit of **£5.7m** after receipt of **£4.2m** of Provider Sustainability Funds and Financial Recovery Funds which related to the current year. This means that the Trust were off plan by **£6.3m**, on an overall cost base of **£335.1m** (i.e. **1.9%**). Further detail on the Foundation Trust's financial performance is covered on pages 49 and 50 of the Annual Report.

◆ Performance targets

We have met all but one of the nationally mandated targets for the year; the exception was the Mental Health Services Data Set Outcomes, for which we changed the way we calculated the target in year following clarification of national guidance. Generally we achieve the **50%** target across all localities except Southampton, however, due to the large caseload size in this geography, this means that the overall performance is **45%**. The average for the rest of the Foundation Trust is **60%**.

Data quality compliance is frequently reviewed, and the previously developed kite mark system for core standards continues to provide oversight and assurance.

Nigel Pascoe QC Independent Investigation Report

In February 2020, NHS Improvement published a report which detailed the findings of an investigation undertaken by Nigel Pascoe QC over the preceding year. The review covered the deaths of four patients under the care of Southern Health NHS Foundation Trust between 2011–2015. It was commissioned by NHS Improvement, following a request by the Trust for external support in investigating the outstanding concerns of the families involved. The report was highly critical of the way in which the Trust managed its own investigations of the deaths at the time and of the way in which the families were treated. A limited public investigation hearing is planned by NHS Improvement as a follow-up to this review to consider the Trust's progress since the deaths in question in respect of key policy areas such as clinical risk management, complaints handling and the investigation of deaths.

Out of Area Placements

As described on page 47, meeting the demand for Acute Mental Health beds within the number of beds historically commissioned by our local CCGs remained a challenge in 2019/20. The ongoing use of such placements presents a significant challenge in terms of patient experience, as well as that of the families and carers of our patients, and maintaining assurance on the quality of service provision; it also has had a significant impact on the Trust's financial position.

The Trust has taken positive action in 2019/20 to reduce the reliance on the use of out of area placements and we are finalising work with CCG colleagues to have the correct balance of beds and community services in Hampshire.

Capital Overspend on Secure Services

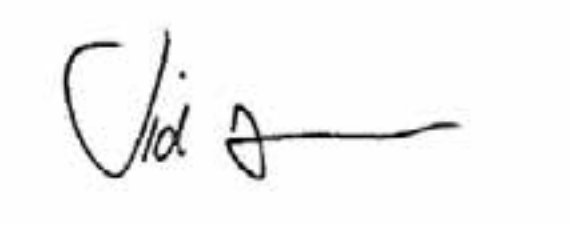
During summer 2019 an overspend was identified against the approved capital programme for the Secure Services redesign. A review was commissioned by the Foundation Trust from BDO, and a report provided to the Board. Improvements have been made to the financial governance around these schemes, further cash mitigations have been achieved and there have been no new overspends occurring; the Board was satisfied that all additional expenditure was justified.

Conclusion

As part of my review of effectiveness I must declare whether the Foundation Trust has any significant control issues and set out the actions to be taken to address these.

In summary, my review confirms that there have been no significant control issues in 2019/20. Where control weaknesses have been identified, action has been taken or improvement plans are in place to address these issues.

Signed:



Dr Nick Broughton, Chief Executive

2 June 2020

APPENDIX A

SOUTHERN HEALTH NHS FOUNDATION TRUST MODERN SLAVERY ACT STATEMENT 2019

Introduction

At Southern Health NHS Foundation Trust we are aware of potential risks regarding modern slavery or human trafficking in our business and our supply chain. This statement sets out the steps we have taken to understand the potential modern slavery and human trafficking risks throughout our organisation.

Please see our Modern Slavery Act Statement:

www.southernhealth.nhs.uk/about/safeguarding-children-and-adults/modern-slavery-statement/

Action taken to address modern slavery during 2018/19

We have continued to review non-capital contracts to ensure that each contractor meets their requirements for the Modern Slavery Act.

During 2018–19 following discussion with local partners, we refined our response to the health needs of potential victims of modern slavery. We now respond to these via existing mainstream services and have identified a lead service for this.

We updated our Disclosure and Barring Service (DBS) and Employment Checks Policy, which addresses issues of verification of identity and right to work checks, to ensure that it is current and reflects best practice.

The Trust has continued its membership of the Hampshire, Isle of Wight, Portsmouth and Southampton Modern Slavery Partnership (MSP) with an aim of contributing towards raising awareness of modern slavery, working in partnership, sharing good practice and supporting victims. The Trust is actively participating in a collaborative event to raise awareness of modern slavery across our organisations and the public on Antislavery Day on 18 October 2019 and has circulated supporting information to all staff members to increase awareness regarding spotting signs of potential slavery and how to report concerns.

Information about modern slavery and human trafficking, including how to identify and respond to concerns and how to report suspected cases of modern slavery is included in our Safeguarding Children and Adults training which all staff have to complete when starting work with the Trust and update every 3 years. Over **97%** of staff are currently compliant with this requirement.

Our Level 1 electronic learning has been updated to meet the new requirements in respect of modern slavery contained in the UK Core Skills Training Framework. We have additionally added a video resource on modern slavery to the staff intranet, available for all staff to access.

We have also updated the page dedicated to information about modern slavery on our staff website to include additional information, including reminding practitioners of the need to use interpreters from recognised services as applicable, the Modern Slavery Helpline telephone number, how to share non-urgent information with the Police and additional contacts for further information.

Advice and support regarding modern slavery concerns continues to be available to all staff from via our safeguarding adults support and advice line, which is run by members of our Trust safeguarding team.

APPENDIX B

■ SOUTHERN HEALTH NHS FOUNDATION TRUST 2019/20 SUSTAINABILITY REPORT

Introduction

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. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources and the climate emergency. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) and NHS Standard Terms are met, while supporting the NHS Long Term Plan and NHS 'For a Greener NHS' initiative.

In order to fulfil our responsibilities for the role we play, our Trust has the following sustainability mission statement located in our 'Green Plan' (previously called the Sustainable Development Management Plan (SDMP):

'Deliver a sustainable health and care service that works within the available environmental and social resources protecting & improving health now and for future generations.'

As a part of the NHS, public health and social care system, it has been our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by **34%** (from a 1990 baseline), equivalent to a **28%** reduction from a 2013 baseline by 2020. Given the recent revision to the UK Climate Change Act which now seeks 'net zero' emissions by 2050 the Trust seeks to support this goal through relevant targets and actions. This includes an interim target to reduce emissions by **60%**, by 2030 relative to a 2013 baseline.

Our Green Plan also reflects the need to support the transition to a circular economy, protect scarce natural resources, improve local air quality and the resilience of our estate, addressing social inequalities within our region and ethical sourcing of goods and services.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

One of the ways in which an organisation can embed sustainability is through the use of a Green Plan, which is supported by a set of SMART actions designed to deliver the Plan's objectives and targets. An up to date Plan is being finalised and will be published in 2020.

Key direct contracts are assessed from a sustainability perspective, relevant and proportionate requirements incorporated and these are monitored through contract management.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Sustainable Development Assessment Tool (SDAT). As an organisation that acknowledges its responsibility towards creating a sustainable future, we have exceeded our SDAT target of **70%** by our 2020 deadline and will be setting further improvement targets.

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.

Our organisation is starting to contribute to the following UN Sustainable Development Goals (SDGs).

Our organisation is clearly contributing to the following Sustainable Development Goals (SDGs).

The Trust has a Modern Slavery Statement and requires suppliers to provide the same and demonstrate how they meet the legal requirements and prevent slavery in the supply chain.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. For commissioned services here is the sustainability comparator for our CCGs (please note this is published a year in arrears):

Organisation Name	Green Plan or SDMP	SDAT	SD Reporting score
NHS Fareham and Gosport CCG	No	n/a	Good
NHS West Hampshire CCG	No	n/a	Minimum
NHS North Hampshire CCG	No	n/a	Excellent
NHS Southampton CCG	No	n/a	Good
NHS North East Hampshire and Farnham CCG	No	n/a	Good
NHS Portsmouth CCG	No	n/a	Good
NHS South Eastern Hampshire CCG	No	n/a	Minimum

As an active member of the local Public Sector Sustainability Group, the Trust continues to work in partnership with other organisations in Hampshire, including local government, universities, Ministry of Defence, armed services and other NHS organisations to improve sustainability.

PERFORMANCE

Organisation

Since 2007 the NHS has undergone a significant restructuring process and one which is still on-going. Therefore, in order to provide some organisational context, the following table may help explain how both the Trust and its performance on sustainability has changed over time.

	2013	2014	2015	2016	2017	2018	2019
Floor Space (m2)	151,000	135,571	109,940	98,532	102,209	108,633	108,036
Number of Staff	6,533	6,337	5,874	5,198	4,997	5,047	5,166

In 2014 the health and Social Care Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS as a system by **28%** (from a 2013 baseline) by 2020. We have supported this ambition by taking action across a range of areas:

Energy

The Trust spent **£1,628,711** on energy in 2019, which is a **1%** increase on energy spend from the previous year.

Performance

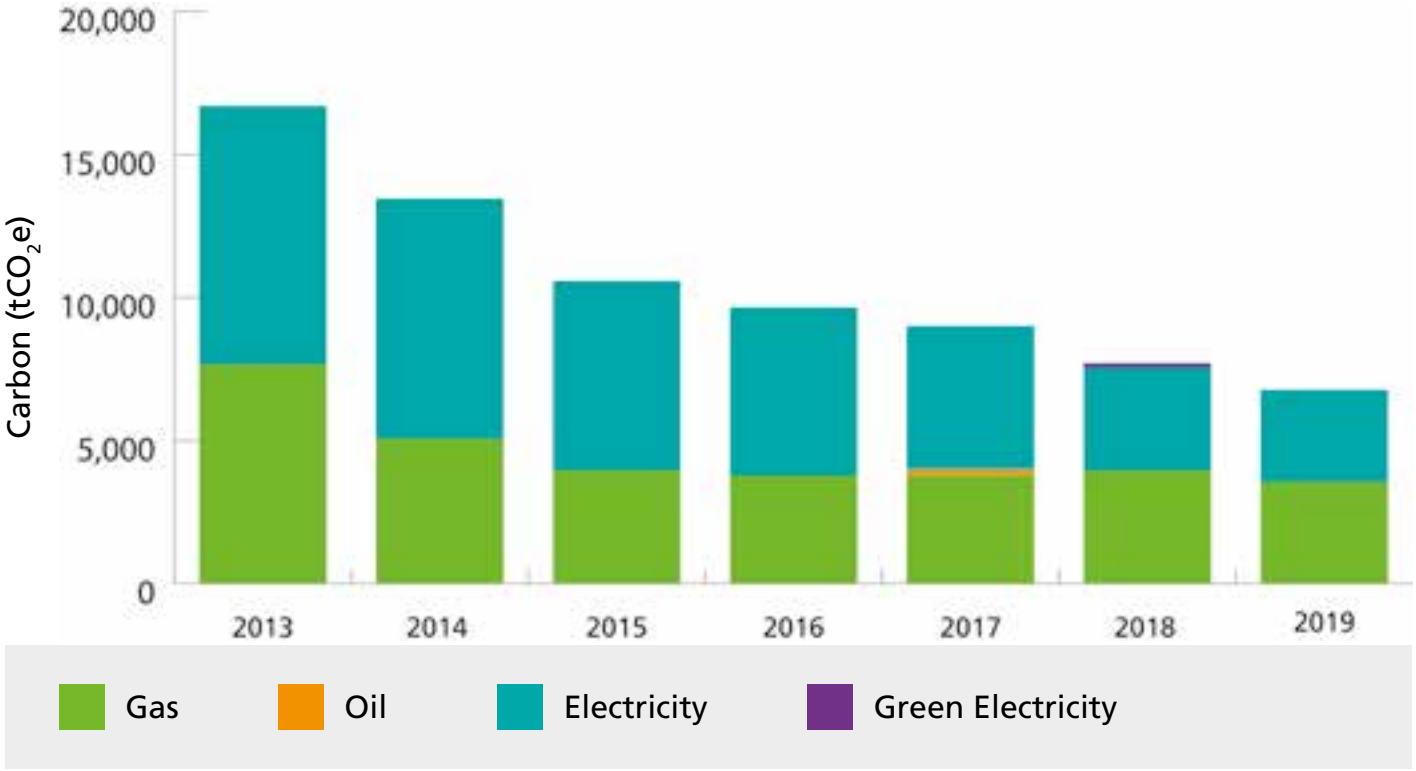
From 2013 to 2018 the Trust reduced energy consumption from **52,275,000 kWh** to **29,485,963 kWh**.

During this period there were various changes to the Trust's estate as well as measures to reduce energy consumption. This also includes energy consumption within sites where the Trust operates, which are owned and managed by NHS Property Services (accounting for approximately **25%** of the total Trust energy consumption).

For the 2019/20 year energy consumption at NHS Property Services sites has been assumed to be the same as 2018, due to the availability of data. The total of energy consumption in 2019 is therefore stated as **27,302,465 kWh**. This represents a **47%** reduction since our baseline year of 2013.

Based on latest carbon factors our energy consumption created **6,774 tonnes** of carbon dioxide emissions equivalent (tCO_2e), which is a **59%** decrease from our 2013 baseline, significantly ahead of the NHS target.

Carbon emissions – Energy use



Resource	Mode	2013	2014	2015	2016	2017	2018	2019
Gas	kWh	36,138,815	24,141,146	18,902,558	18,091,956	18,146,945	18,855,970	17,120,033
	tCO_2e	7,666	5,065	3,956	3,781	3,786	3,951	3,557
Oil	kWh	0	0	0	0	658,789	0	0
	tCO_2e	0	0	0	0	215	0	0
Electricity	kWh	16,136,618	13,550,424	11,510,476	11,374,404	11,230,399	10,220,993	10,182,432
	tCO_2e	9,035	8,392	6,618	5,878	5,006	3,606	3,217
Green Electricity	kWh	0	0	0	0	0	409,000	0
	tCO_2e	0	0	0	0	0	144	0
Total Energy CO_2e		16,702	13,457	10,574	9,659	9,068	7,701	6,774
Total Energy Spend		£2,143,334	£2,145,717	£1,647,769	£1,503,189	£1,548,064	£1,611,510	£1,628,711

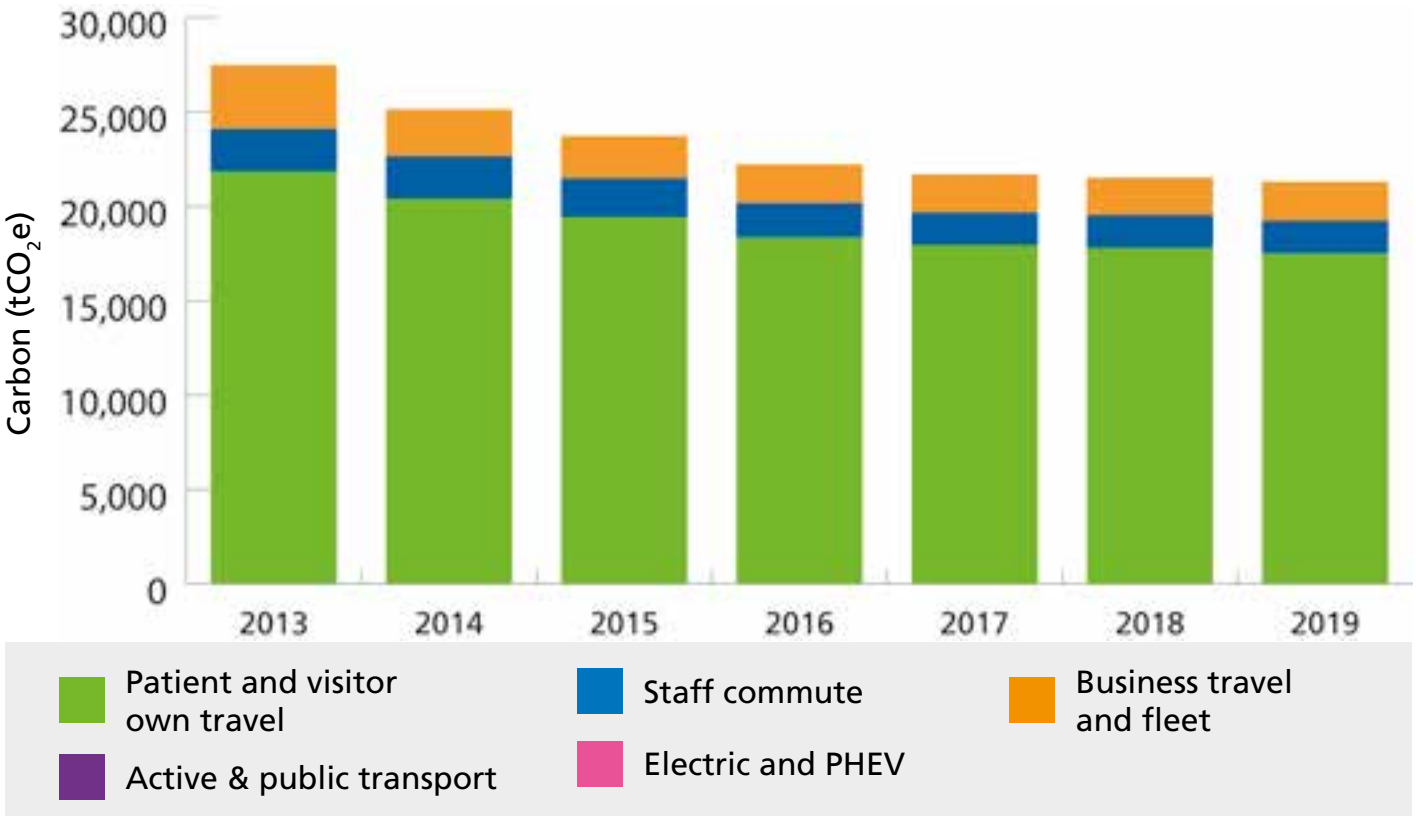
Commentary

As part our sustainable energy improvements, our Estates Maintenance team continues to implement energy efficiency measures, such as improved boilers, heating controls and increased insulation, and our Legal Property team continue to rationalise our estate.

Travel

The Trust spent **£4,575,535** on business travel in 2019, which is virtually unchanged from 2018.

Carbon emissions – Travel



Category	Mode	2013	2014	2015	2016	2017	2018	2019
Patient and visitor own travel	Miles	59,200,209	55,550,886	53,623,561	50,830,841	50,398,722	49,993,938	50,702,128
	tCO_2e	21,872.89	20,411.02	19,444.73	18,370.79	17,958.32	17,814.08	17,520.00
Staff commute	Miles	5,998,126	6,087,433	5,642,668	4,995,095	4,802,117	4,848,333	4,964,526
	tCO_2e	2,216.15	2,236.70	2,040.59	1,805.28	1,711.11	1,727.58	1,715.00
Business travel and fleet	Miles	9,169,429	6,786,155	6,186,068	5,636,768	5,653,167	5,520,744	5,945,928
	tCO_2e	3,387.86	2,493.43	2,237.10	2,037.19	2,014.36	1,967.18	2,057.00
Active & public transport	Miles	0	0	0	0	59,801	63,089	33,791
	tCO_2e	0.00	0.00	0.00	0.00	5.36	5.47	2.67
Electric and PHEV	Miles	0	0	0	0	15,570	10,796	16,218
	tCO_2e	0.00	0.00	0.00	0.00	1.77	1.23	1.85
Total Business Travel tCO_2e		3,388	2,493	2,237	2,037	2,021	1,974	2,062
Total Business Travel Spend		£ –	£ –	£6,034,526	£5,648,637	£4,697,854	£4,514,888	£4,575,535

Performance

Our Trust travelled **5,995,937 miles** on business in 2019, which is a **7%** increase on business travel from 2018, but a **35%** decrease from our 2013 baseline.

Our business travel created **2,062 tonnes** of carbon dioxide emissions equivalent (tCO_2e), which is a **4%** increase from 2018, but a **39%** decrease from our 2013 baseline.

Patient and visitor travel emissions and those arising from staff commuting shown in the above chart are estimates based on NHS travel survey data and assumptions. They are therefore indicative only. It is the intention that the Trust will undertake further work to identify the impact of these activities on emissions arising (CO_2e, but also emissions that contribute to poor air quality) and measures to reduce this impact.

Commentary

We recognise that a Healthy Transport Plan is a foundational part of our Travel Policy and we keep this under review.

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 (CO_2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

Our Sustainable Travel Policy mandates CO_2e emission levels for our fleet vehicles and encourages staff to adopt a sustainable travel hierarchy:

- Firstly, avoid travel wherever possible by using on-line meetings, and
- Where travel cannot be avoided, then reduce emissions associated with the travel by choosing low emission transport.

To help facilitate this, the Trust continues to invest in additional electric vehicles and charging points. We now have five electric vans and two electric pool cars.

We have also continued a social change initiative to reduce local air pollution with volunteers from our staff.

Procurement

Our Trust spent **£83,316,339** on non-pay expenditure in 2019, which is a **6%** increase on non-pay spend in 2018.

Performance

Our Trust non-pay procurement created **35,490 tonnes** of carbon dioxide emissions equivalent (tCO_2e) in 2019, which is an **8%** increase from 2018, but a **10%** decrease from our 2013 baseline. Major sources of emissions from procurement arise from:

- Building Services (**29%**),
- Staff and Patient Consulting Services (**24%**),
- Office Equipment (**13%**),
- Facilities Management Services (**10%**), and
- Pharmaceuticals (**6%**).

Commentary

Emissions from procurement are indicative as they are based on Trust non-pay expenditure on goods and services. In practice related emissions may be reduced by a relevant focus within contracts let by the Trust, as well as the establishment of procurement arrangements by NHS Supply Chain in conjunction with suppliers on the Trust's behalf. The Trust will therefore work with its supply chain to seek relevant reductions in emissions while identifying opportunities for enhancing social value (e.g. skills and training, employment opportunities for disadvantaged groups and others).

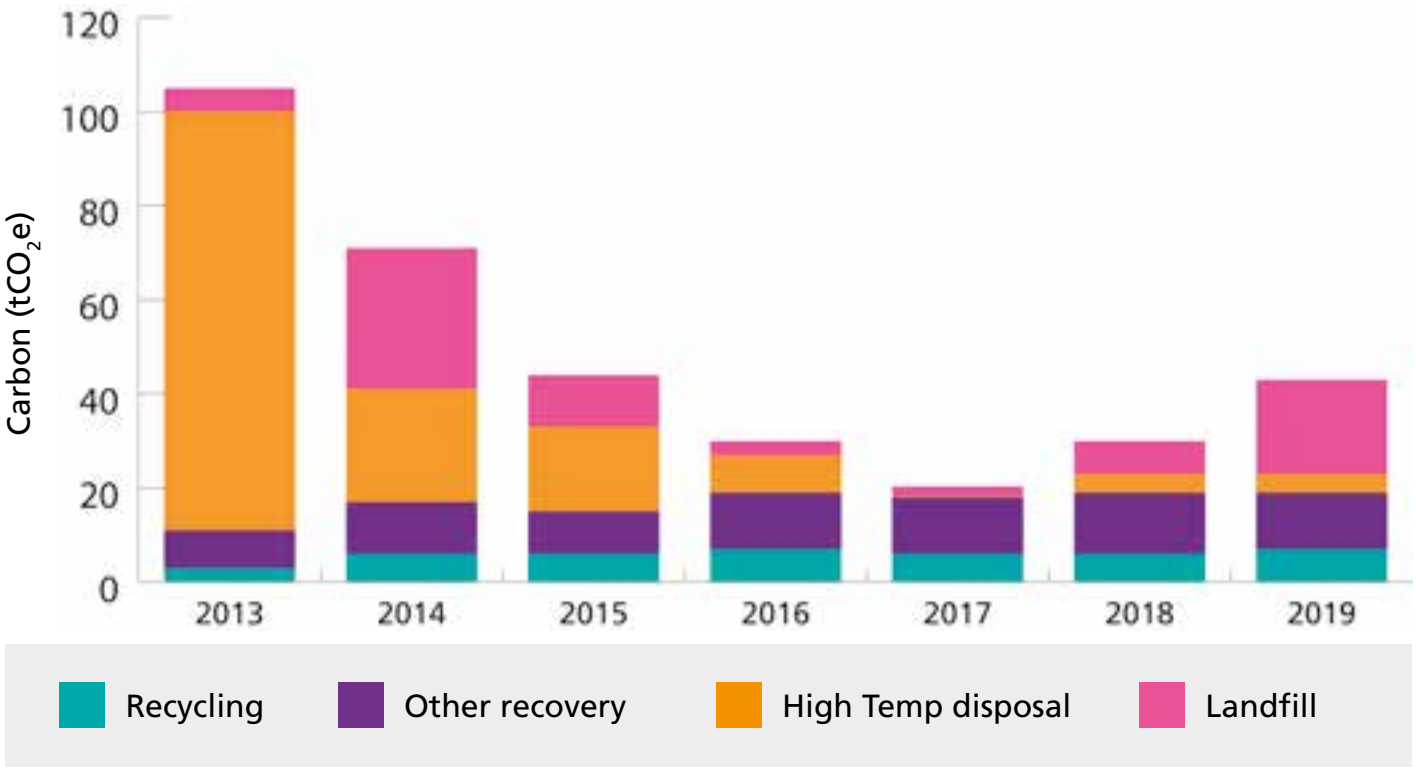
Our Sustainable Procurement Policy and Procedure ensures our procurement activities consider and seek to address the environmental and ethical impacts of the goods and services we purchase. Collectively as an organisation we recognise the contribution that commissioning, procurement and commercial can have in delivering sustainability and social value, and our duty under the Public Services Value Act.

This focus on sustainable procurement improvements has reduced the carbon footprint of our goods and services but also eased congestion and improved air quality within our region. The Trust has also signed up to the NHS Plastics Pledge and we are currently working to remove single use plastics from our catering and hospitality services.

Waste

Our Trust spent **£264,303** on waste management in 2019, which is a **17%** decrease on spend in 2018.

Waste breakdown



Waste		2013	2014	2015	2016	2017	2018	2019
Recycling	tonnes	157	282	278	342	262	284	336
	tCO_2e	3	6	6	7	6	6	7
Other recovery	tonnes	362	508	458	567	556	584	552
	tCO_2e	8	11	9	12	12	13	12
High Temp disposal	tonnes	403	111	84	38	2	19	18
	tCO_2e	89	24	18	8	0.34	4	4
Landfill	tonnes	19	124	45	10	6	21	57
	tCO_2e	5	30	11	3	2	7	20
Total Waste (tonnes)		941	1025	865	958	826	907	963
% Recycled or Re-used		17%	28%	32%	36%	32%	31%	35%
Total Waste tCO_2e		104	71	44	31	20	30	43
Total Waste Spend		£ 229,965	£ 331,789	£ 350,214	£ 234,517	£ 296,407	£319,275	£264,303

Performance

Our Trust produced **963 tonnes** of waste in 2019, which is a **6%** increase from last year and a **2%** increase from our 2013 baseline. Our waste created **43 tonnes** of carbon dioxide emissions equivalent (tCO_2e), which is a **43%** increase from last year but a **59%** decrease from our 2013 baseline. The proportion of waste recycled in 2019 increased to **35%**.

Commentary

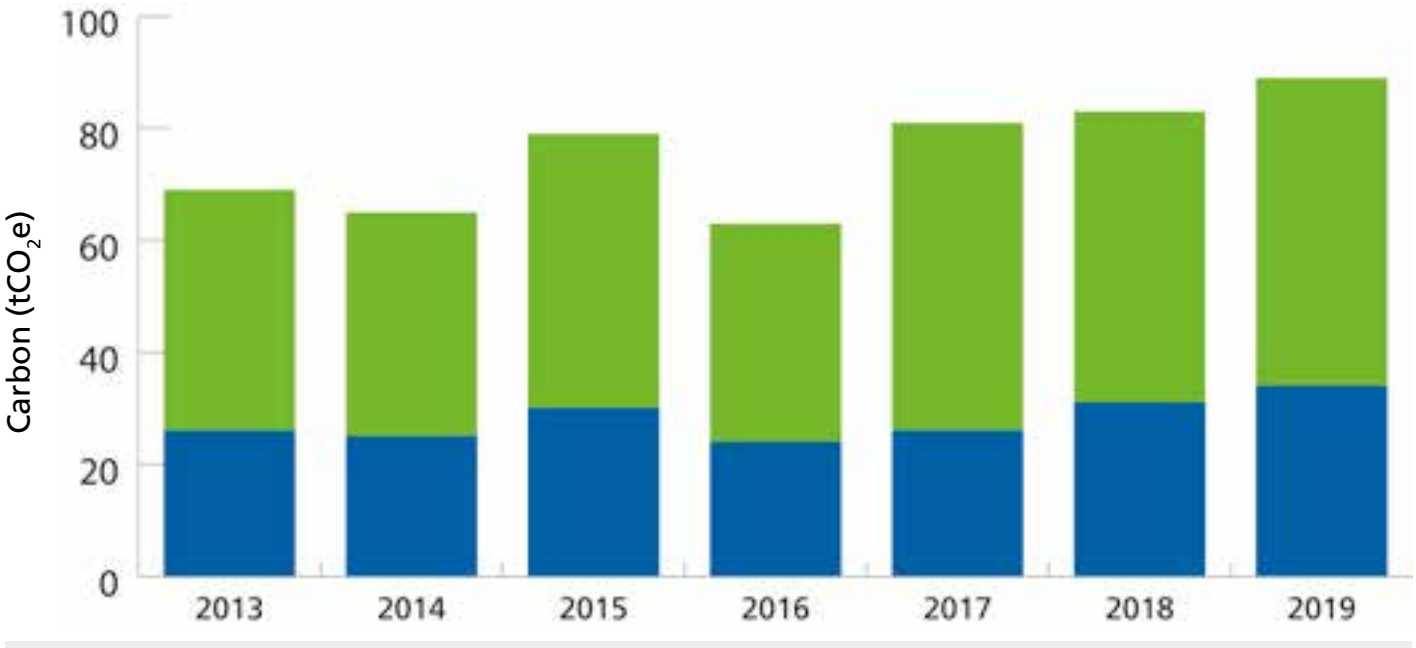
As part of our sustainable waste improvements, we are continuing to work with our Managed Waste Supplier to seek increased recycling rates and decrease our landfill and high temperature disposal.

Within the Trust we adopt the waste hierarchy; firstly, avoid creating waste wherever possible by reusing and relocating equipment, furniture and other assets within the Trust and, if they are no longer required by the Trust, then selling or gifting the items to charities and other organisations or individuals. Such a focus on reuse, extending the useful life of assets, avoiding waste and the use of virgin raw materials where practical supports the transition to a circular economy.

Water

Our Trust spent **£245,167** on water and sewage in 2019, which is a **4%** decrease on water and sewage spend in 2018.

Carbon emissions – Water



Water		2013	2014	2015	2016	2017	2018	2019
Mains Water	m^3	76,164	71,275	87,292	69,494	97,740	91,450	97,963
	tCO_2e	26	25	30	24	26	31	34
Waste Water & Sewage	m^3	60,931	57,020	69,834	55,595	60,194	73,232	78,370
	tCO_2e	43	40	49	39	55	52	55
Water & Sewage Spend		£ 302,942	£ 323,412	£ 325,612	£ 249,284	£ 256,350	£ 255,197	£245,167

Performance

Our Trust used **97,963 cubic metres** of water and created **78,370 cubic metres** of wastewater and sewage in 2019.

Our water usage, wastewater and sewage created **89 tonnes** of carbon dioxide emissions equivalent (tCO_2e), which increased by **7%** in 2019 and by **28%** from our 2013 baseline.

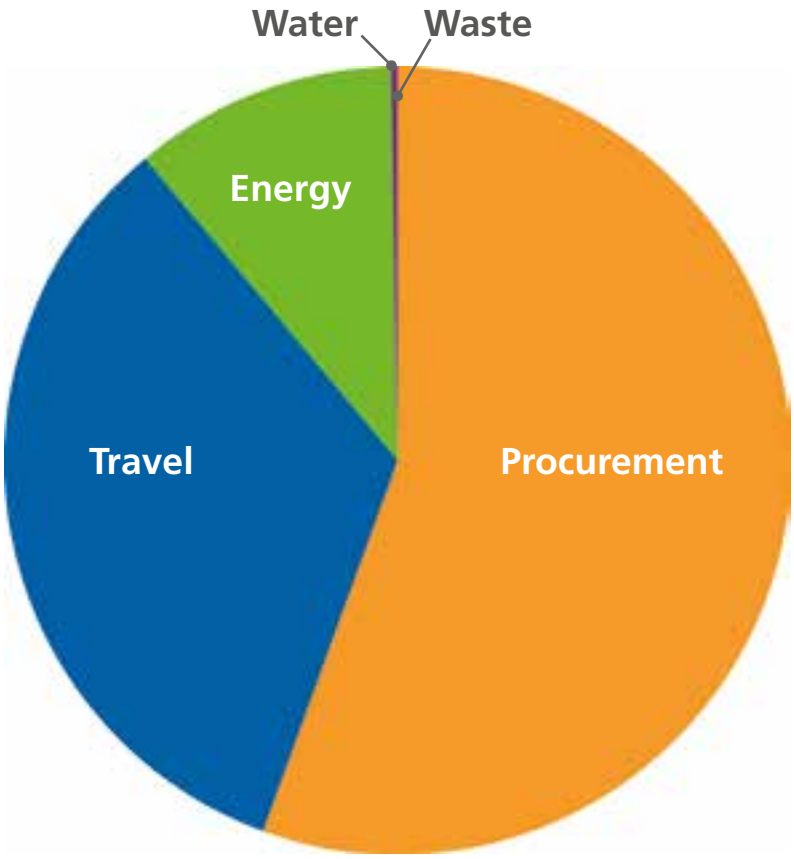
Commentary

As part our sustainable water improvements, our Estates Maintenance team continues to implement water efficiency measures, such as prevention and reduction of leaks, prompt maintenance of dripping taps, and installing water saving devices, such as hippo bags and auto plungers.

Carbon Footprint analysis

Our 2019 Trust activities resulted in an estimated total carbon footprint of **63,693 tonnes** of carbon dioxide equivalent emissions (tCO_2e), the breakdown of which is shown below.

2019 Carbon footprint breakdown – Tonnes CO_2e



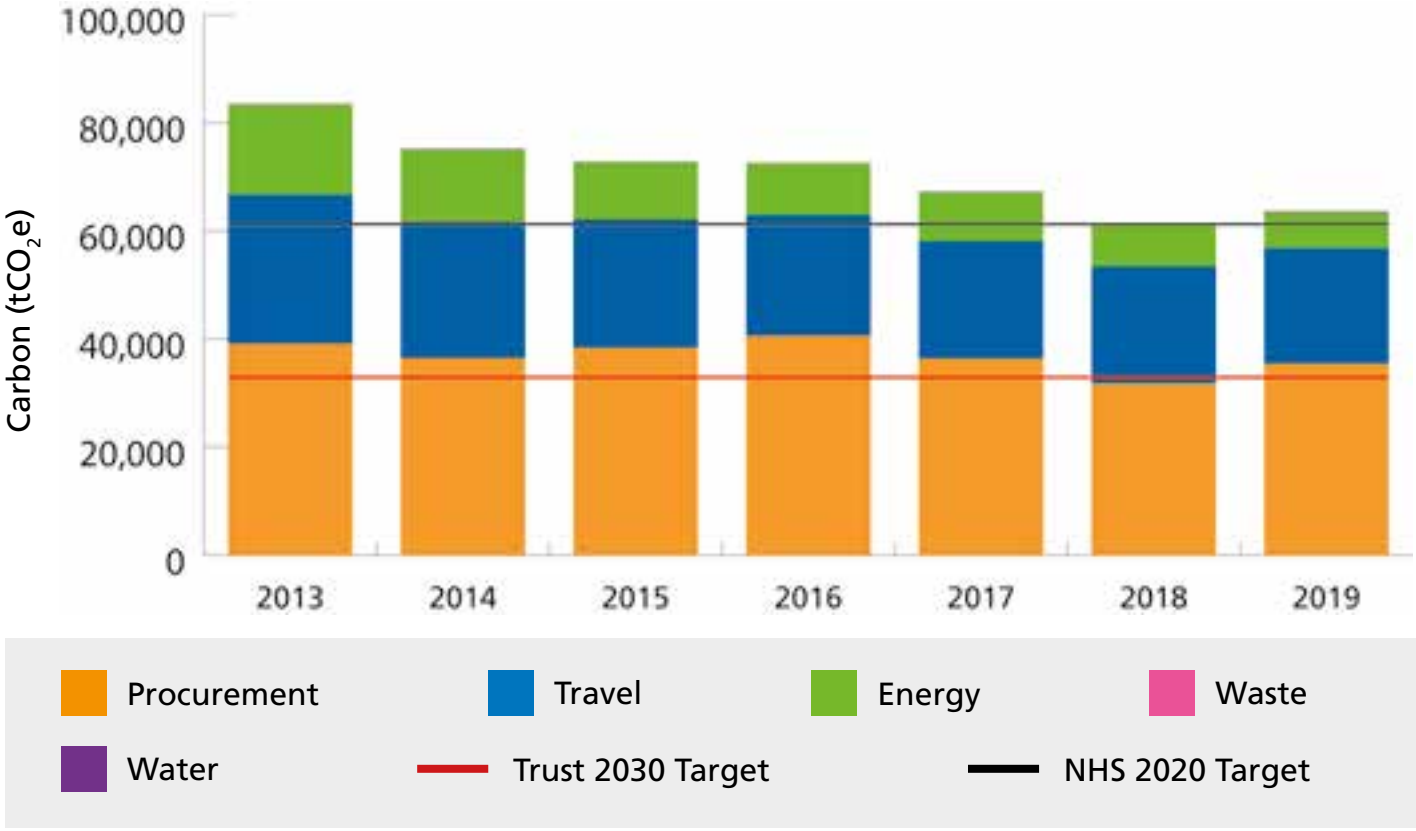
Category	Tonnes CO_2e	% CO_2e (approx.)
Energy	6,774	11%
Travel	21,297	33%
Procurement	35,490	56%
Waste	43	< 0.1%
Water	89	< 0.1%

This represents an overall **24%** reduction from our 2013 baseline (some adjustments have been made to historic emissions following clarification of relevant data).

CORE emissions (those which are directly controlled by the Trust – energy, waste, water and business travel) amount to a total of **8,968 tonnes** CO_2e. These have reduced by **55%** since 2013, significantly ahead of the NHS target of **28%** reduction by 2020 and on track to deliver the Trust's target reduction of **60%** by 2030.

Emissions from other sources – procurement, patient and visitor travel and staff commuting – have reduced since 2013 by **13%**. Further reduction in emissions and related health and wellbeing outcomes from these sources will reflect the need to work collaboratively with our community, staff, supply chain and local, regional and national strategic partners.

Organisation carbon footprint by source



Adaptation

While our focus is on reducing emissions that contribute to the worst effects of climate change from various sources, it is also recognised that the climate is changing, and we must adapt to this new situation. This change brings new challenges to the Trust both in direct effects to the healthcare estates, but also to patient health. Examples in recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, fire and droughts. Our board approved adaptation plan addresses the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events, while ensuring resilience of supply.

Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that our services continue to meet the needs of our local population during such events we have developed and implemented a number of policies and protocols in partnership with other local agencies, including a Climate Change Adaption and Business Continuity Plans and these continue to be enhanced.

Biodiversity Action Plan

In the last year we also launched our Nature Gardens initiative to unlock the opportunity and benefits of natural capital within a healthcare environment in supporting the health and wellbeing of patient, staff and the community whilst to protect biodiversity.

Working in partnership with local authorities, colleges, charities and the third sector, including New Forest National Park Authority, Minstead Trust, Groundworks, to name a few, we continue to evaluate and improve our natural estate.

Summary

We have enhanced our sustainability assessment score and remain on track to deliver reductions in CORE emissions in accordance with our strategic target.

Whilst we have made good progress in reducing our overall environmental impact over the last 12 months we recognise that more needs to be done in order to support the UK's essential transition to a low carbon, 'net zero' and circular economy and relevant social and ethical improvement.

During 2019 we have continued to reduce CORE emissions, although significant reductions in energy emissions were offset by small increases in those from waste, water and business travel. We remain on track to deliver reductions in CORE emissions in accordance with our strategic target.

Our sustainability performance does not just reflect a focus on emissions. We have reassessed our overall sustainability status in accordance with the Sustainable Development Assessment Tool (SDAT) and we are pleased to have improved our overall performance to one of the highest (based on a review of SDAT scores published by other Trusts). As well as emissions this considers the Trust's approach to Corporate management, Asset Management and Utilities, Travel and logistics, Capital projects, Green space and biodiversity, Sustainable care models, our People and the Sustainable use of resources.

While we are therefore meeting the overall objectives of our Sustainable Development Management Plan we recognise that more needs to be done in order to support the UK's essential transition to a low carbon, 'net zero' and circular economy and relevant social and ethical improvement. This is reflected in the Trust's new Green Plan which will be published in 2020.

GLOSSARY

AHP	Allied Health Professional
BAME	Black, Asian and Minority Ethnic
BLS	Basic life support training
CAMHS	Child and Adolescence Mental Health Services
CCG	Clinical Commissioning Group
COG	Council of Governors
Commissioner	Member of Clinical Commissioning Groups (CCGS)
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Framework
EIP	Early Intervention in Psychosis
FFT	Friends and Family Test
Healthwatch	Healthwatch is an independent organisation which ensures the voice of patients and carers are heard. They raise issues of concern and work with organisations to improve services.
LGBTQ+	Lesbian, gay, bisexual, transgender, queer and other
MDT	Multidisciplinary Team
MECC	Making every contact count
MHA	Mental Health Act
MIU	Minor Injuries Unit
MSK	Musculoskeletal services – any injury, disease or problems with your muscles, bones or joints
NEWS2	National Early Warning Score - used to identify and respond to patients at risk of deteriorating
NICE	National Institute of Health and Care Excellence
NIHR	National Institute for Health Research
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement

PEWS	Paediatric Early Warning score - used to identify and respond to paediatric patients at risk of deteriorating
PICU	Psychiatric Intensive Care Unit
Q1, Q2, Q3, Q4	Quarter 1 (April to June), Quarter 2 (July to September), Quarter 3 (October to December), Quarter 4 (January to March)
RiO	Our electronic patient record
RTT	Referral to Treatment
Tableau	Our business intelligence reporting system which allows us to measures and monitor our performance.
Triangle of Care	A programme launched in July 2010 between the Carers Trust and the National Mental Health Development Unit, emphasising the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental ill-health.
WRES	Workforce Race Equality Standard

Independent auditors' report to the Council of Governors of Southern Health NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Southern Health NHS Foundation Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2020 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20.

We have audited the financial statements, included within the Annual Report and Accounts 2019/20 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2020; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Taxpayers' Equity for the year ended 31 March 2020; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1.2 to the financial statements concerning the Trust's ability to continue as a going concern.

The Board of Directors recognise the risk that the Trust might fail to deliver on its financial plan and require financial support from the Secretary of State during the course of 2020/21 in order to meet its liabilities and continue to provide healthcare services. The extent and nature of the financial support required, including whether such support will be forthcoming or sufficient, is currently uncertain, as are any terms and conditions associated with the funding.

These conditions, along with the other matters explained in note 1.2 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Explanation of material uncertainty

The financial arrangements that have been put in place by NHS Improvement / England ("NHSI/E") to support the sector's response to Covid-19, including the suspension of the 2020/21 planning process and contract negotiations with Commissioners, has resulted in uncertainty regarding the Trust's financial position for the next 12 months from the date the financial statements are signed. The Trust had a plan agreed within the Hampshire and Isle of Wight Integrated Care System, which showed a planned deficit of £11.4m for 2020/21, but following the financial arrangements that have been put in place by NHSI/E through to October 2020, the Trust has prepared a revised financial plan for 2020/21 that demonstrates a planned break-even position. This is based on the assumption that NHS providers will receive a guaranteed minimum level of income reflecting their current cost base and additional Covid-19 expenditure, will be funded in full by NHSI/E.

The Department of Health and Social Care Group Accounting Manual 2019/20 requires that the 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 a NHS Foundation Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

What audit work we performed

In considering the financial performance of the Trust and the appropriateness of the going concern assumption in the preparation of the financial statements, we obtained the 2020/21 financial plan as well as the Trust's cash flow forecasts until the end of June 2021 and:

- compared the financial plan against the Trust's previous financial performance and understood the key assumptions underlying the financial plan;
- examined the impact of cash flow sensitivities and assessed these against the Trust's ability to meet its liabilities as they fall due;
- sensitised the assumptions behind the Trust's financial forecasts to determine the impact of changing these assumptions on the forecast cash flows;
- made enquiries of management regarding their communications with the Hampshire and Isle of Wight Integrated Care System and NHSI/E;
- reviewed the financial guidance currently issued by NHSI/E with respect to 2020/21 and their statement to support provider forecasting; and
- read the disclosures regarding going concern included in the Annual Report and Accounts.

Our audit approach

Context

Our audit for the year ended 31 March 2020 was planned and executed having regard to the fact that the Trust's operations were largely unchanged in nature from the previous year, but its financial position had deteriorated as a result of the unplanned deficit for the year. In light of this, our approach to the audit in terms of scoping and key audit matters was largely unchanged, apart from consideration of the material uncertainty relating to going concern, and assessment of the impact of Covid-19.

Our audit also involved forming a conclusion on the arrangements for securing economy, efficiency and effectiveness in the use of resources (the "3 Es"), in accordance with the Code of Audit Practice.

Overview

- Overall materiality: £6,747,000 (2019: £6,315,000) which represents 2% of total revenue
- In establishing our overall approach we assessed the risks of material misstatement and applied our professional judgement to determine the extent of testing required over each balance in the financial statements
- The Key Audit Matters identified were:
    - Risk of fraud in revenue and expenditure recognition;
    - Valuation of the Trust's estate;
    - Material uncertainty relating to going concern;
    - Impact of Covid-19; and
    - Value for Money

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and the conclusion on the arrangements for securing economy, efficiency, and effectiveness in the use of resources, and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a

whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified by our audit.

Key audit matter	How our audit addressed the key audit matter
Risk of fraud in revenue recognition *See note 1 to the financial statements for the directors' disclosures of the related accounting policies relating to the recognition of income and expenditure for further information.* We focused on these areas because the Trust had a financial incentive this year to understate the result, as by the year end, it was known that the control total agreed with NHS Improvement ("NHSI") had not been met. The Trust missed its revised control total of a £5.6m deficit by £4.2m, ending the year with a £9.8m deficit (on a control total basis), primarily due to the cost of unplanned out of area placements. As a result, the Trust did not receive core Provider Sustainability Fund ("PSF") funding for Q4. It did however, receive core PSF for Q1 to Q3 (£2.6m) and £1.5m of Financial Recovery Fund ("FRF") funding for having signed up to achieving the control total. There was a risk that management would understate the financial result for the year to help meet the control total next year: • Income may be recognised in 2020/21 that relates to 2019/20. • Expenditure in 2019/20 may be overstated or expenditure relating to 2020/21 may be recognised in 2019/20. *Income* The Trust's principle source of income is from Clinical Commissioning Groups ("CCGs"), local authorities and NHS England. The service level agreements (block contracts) with the CCGs, local authorities and NHS England are annual and the majority of the income is fixed for the year and does not fluctuate with the level of activity. There may be contract variations to the block contracts signed during the year. These elements are more subject to management judgement regarding the income to which the Trust is entitled. The remainder of the Trust's income arises from a range of sources, for example, through the provision of non-statutory Social Care Services, Education & Training and Research & Development. These income streams are more variable in nature than the block contract income and are subject to differing terms and conditions and hence, more subject to management judgement regarding the amount and timing of income that is recognised. We therefore focused our testing on block contract variations and non-block contract income. *Expenditure* The Trust's operating expenditure relates to employee expenses and remuneration, transactions with other NHS organisations and payments for supplies, premises and other operating costs both to other public sector organisations and commercial third parties. We focused our testing on non-employee and non-depreciation expenditure, as we considered this expenditure to be the most susceptible to misstatement.	We focused our work on the elements of income and expenditure that are the most susceptible to manipulation, being: • Non-standard journal transactions, including those that debit income and credit non-NHS receivables; and those that debit expenditure and credit non-NHS receivables; • Income and expenditure items recognised around the year end date, which may be recognised in the wrong period; and • Items of expenditure where the value recognised at year end is estimated, including accruals and provisions. *Journals* We selected a risk-based sample of manual and automated journal transactions that had been recognised in both income and expenditure, focusing in particular on non-standard transactions as outlined above. We traced these journal entries to supporting documentation (for example, invoices, cash receipts or payments) and found that, without exception, the supporting documentation demonstrated that the journal was appropriate and had been recognised in the correct period. *Intra-NHS agreement of transactions and balances* We obtained the Trust's mismatch reports received from NHSI, which identified transactions and balances with other NHS bodies (debtor, creditor, income or expenditure balances) that were disputed by the counterparty. We checked that management had investigated all disputed amounts and discussed with them the results of their investigation and the resolution. We read correspondence with the counterparties, which corroborated the discussions. We considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements and determined that there was no material impact. *Income* For non-block contract income and other operating income recognised in the month before and the month after the year end, we agreed a sample of transactions to supporting documentation (for example, signed contract or agreement, an invoice or correspondence), and where possible, to subsequent cash receipt, to check it had been recognised in the correct period. There were no material block contract variations signed during the year. For a sample of deferred income, we understood the conditions under which the income had been deferred and agreed the sampled balances to supporting documentation. *Expenditure* For a sample of accounts payable as at the year end, we tested the amount recognised to invoice or other relevant supporting documentation including contracts. We tested a sample of accrued expenses as at the year-end by agreeing the amount recognised to the subsequent invoice or other relevant supporting documentation including contracts or calculations and agreed estimates and assumptions used to previous charges for the goods/services to check the amount and timing of recognition of the expense. There were no material provisions balances as at 31 March 2020. For a sample of non-employee and non-depreciation expenditure recognised throughout the year we traced the amount that had been recognised to supporting documentation (for example, signed contract or agreement, an invoice, or supporting correspondence).

Impact of Covid-19 During the course of the audit, both management and the engagement team considered the impact that the ongoing Covid-19 pandemic has had on the wider economy and on the activities, workforce and suppliers of the Trust and the resultant impact on the financial statements. Management's assessment is that there has been no significant impact on the financial statements for the year ended 31 March 2020 as the pandemic only started to have a significant impact in the last three weeks of the year. However, due to the significance of the pandemic, the financial statements have recognised the impact as a significant narrative disclosure within the Annual Report. As a result of this, we determined that the impact of Covid-19 should be a key audit matter.	We performed the following procedures to address the impact that Covid-19 has on the financial statements: We evaluated management's assessment of the impact of Covid-19 on the Trust's internal control environment and financial statement transactions and balances: we reperformed our assessment of audit risks and did not identify any additional risks, but we incorporated our assessment of the potential impact of Covid-19 into our existing risks, for example, on the material uncertainty regarding going concern and on the valuation of the Trust's estate; We assessed the impact of Covid-19 and the resulting restrictions to our normal working arrangements on our audit approach; and We read the disclosures made by management in the Annual Report (including in the Annual Governance Statement). We concluded that management's assessment of the impact of Covid-19 on the services and the arrangements for securing economy, efficiency and effectiveness in its use of resources is reasonable as disclosed on pages 22, 128 and 129 of the Annual Report.
Valuation of the Trust's estate Management's accounting policies, key judgements and use of experts in relation to the valuation of the Trust's estate is set out in note 1 of the financial statements. Property, Plant and Equipment (PPE) makes up approximately 84% of the assets held by the Trust and at 31 March 2020 was valued at £202.3m (£189.6m in 2018/19). Land and buildings are initially measured at cost, and subsequently measured at fair value in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20. A desktop valuation of the Trust's land and buildings has been undertaken this year by the District Valuer, in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, using the Modern Equivalent Asset ("MEA") basis of valuation, which involves a range of assumptions being used. The output from this year's valuation exercise has seen the value of the Trust's estate increase overall by £1.7m. The specific risk areas are: • The accuracy of the detailed property information provided to the District Valuer, in particular the land area and floor plans on which the valuation is based, • The methodology, assumptions and underlying data used by the District Valuer (including the application of the MEA), and • The accounting transactions resulting from this valuation. In addition, the valuation exercise was carried out as at 31 January 2020 applying indices for 31 March 2020 which were available by the time the valuation was prepared. Given the events in relation to Covid-19 between 31 January 2020 and 31 March 2020, the Trust requested the valuer to provide an update to the valuation. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 and RICS UK National Supplement commonly known together as the Red Book, the valuer has declared a 'material valuation uncertainty' in the valuation report as a result of Covid-19.	We obtained the output of the valuation undertaken by the District Valuer. We checked and found the valuer had a UK qualification, was part of an appropriate professional body and was not connected with the Trust. We read the relevant sections of the valuation report and, using our own valuation expertise, we challenged the assumptions and methodology applied in the valuation exercise, specifically considering the use of MEA, which we found to be consistent with our expectations. To check the accuracy of the underlying data (on which the valuation was based), we agreed the data used by the District Valuer back to floor and area plans for a sample of land and buildings and found the valuation to be based on current information. We physically verified a sample of assets to check their existence and, in doing so, considered whether there was any indication of physical obsolescence which would indicate potential impairment or affect the valuation of the property; our testing did not identify any such indicators. We checked that the change in valuation was correctly reflected and appropriately disclosed in the financial statements. In relation to the material valuation uncertainty, management has noted that in regard to both specialised and non-specialised in-use assets, there has been no diminution identified in the public sectors ongoing requirement for these assets, nor a reduction in their ongoing remaining economic service potential. In addition, the BCIS indices at 31 January remained unchanged at 31 March and it was too early to assess the impact of Covid-19 on the future BCIS indices. We have read the disclosure regarding the material valuation uncertainty included in note 1.24.

Other than the matters noted in the 'Material uncertainty relating to going concern' and 'Arrangements for securing economy, efficiency, and effectiveness in the use of resources' paragraphs, we determined that there were no further key audit matters relating to the financial statements of the Trust, or the Trust's arrangements for securing economy, efficiency, and effectiveness in the use of resources, to communicate in our report.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Trust, the accounting processes and controls, and the environment in which the Trust operates.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£6,747,000 (2019: £6,315,000)
How we determined it	2% of revenue (2019: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit, Risk and Assurance Committee that we would report to them misstatements identified during our audit above £250,000 (2019: £250,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2019/20 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2020 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 125, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20, and for being satisfied that they give a true and fair view. The directors 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.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable

assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

We are required under Schedule 10 (1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has 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. Based our on risk assessment, we undertook such work as we considered necessary.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Southern Health NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Adverse opinion

As a result of the matters set out in the Basis for adverse opinion section immediately below, we have concluded that the Trust has not put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2020.

Basis for adverse opinion and Key Audit Matter

The Trust was first subject to regulatory action by Monitor (now NHSI) in April 2014, when it was found to be in breach of the conditions of its licence due to governance issues identified and enforcement undertakings were agreed. Further regulatory action was taken by NHSI in January and April 2016 and further enforcement undertakings were agreed in June 2016.

During 2018/19, NHSI lifted some of the enforcement undertakings against the Trust, although the Trust remains in breach of its licence conditions following the failures in corporate governance arrangements identified in 2014 and 2016. Enforcement undertakings remain in place to address governance, quality of care, engagement of stakeholders, and the development and delivery of plans. The Trust reported an unplanned deficit in 2018/19, primarily as a result of the high volume of out of area placements. The cost of unplanned out of area placements continued to affect the Trust in 2019/20 and it reported a further unplanned deficit and a resulting deterioration in its overall financial position.

The Trust was rated as 'Good' overall by the CQC in their report issued in January 2020, which represents an improvement from its previous rating of 'Requires Improvement'. In considering the Trust's arrangements, we have performed the following procedures:

- Read reports and relevant correspondence with the CQC;
- Read relevant correspondence with NHSI on the licence conditions;
- Considered financial performance and financial sustainability by reviewing the 2019/20 outturn and achievement of cost improvement targets; and
- Considered the operational performance of the Trust during the year by reviewing performance reporting.

As a result of the work performed, we have concluded that, although there has been an improvement in the CQC rating during the year, because the Trust remains in breach of its licence conditions and is under enforcement undertakings, and has reported a further unplanned deficit for the period, these matters indicate weaknesses in arrangements for: applying the principles and values of sound governance; managing risks effectively; planning finances effectively; managing and utilising assets effectively; and planning, organising and developing the workforce effectively as defined by Auditor Guidance Note 03 issued by the National Audit Office.

Other matters on which we report by exception

We are required to report to you if:

- the statement given by the directors on page 84, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance, business model, and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual report on pages 66 and 67, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- we have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Sasha Lewis (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Southampton
5 June 2020

Southern Health NHS Foundation Trust

Annual accounts for the year ended 31 March 2020

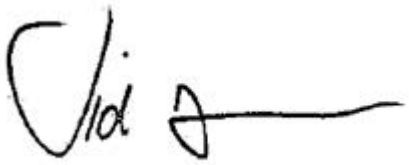
Southern Health NHS Foundation Trust
Annual Accounts for the year ended 31 March 2020

Contents

Foreword to the accounts

Southern Health NHS Foundation Trust

These accounts, for the year ended 31 March 2020, have been prepared by Southern Health NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



Signed ……

Name **Dr Nick Broughton**
Job title **Chief Executive**
Date **2 June 2020**

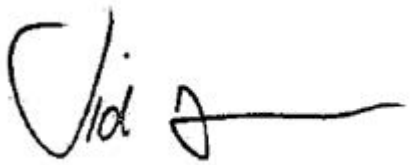
Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	312,044	291,977
Other operating income	4	25,304	23,792
Operating expenses	6	(335,058)	(319,689)
Operating surplus / (deficit) from continuing operations		**2,290**	**(3,920)**
Finance income	11	281	183
Finance expenses	12	(1,212)	(1,196)
PDC dividends payable	12.3	(4,733)	(5,168)
Net finance costs		**(5,664)**	**(6,181)**
Other gains	13	21	3
(Deficit) for the year		**(3,353)**	**(10,098)**
Other comprehensive (expense) / income			
Will not be reclassified to income and expenditure:			
Impairments	7	(6,613)	(903)
Revaluations	17	6,641	4,122
Total comprehensive (expense) for the year		**(3,325)**	**(6,879)**
Adjusted financial performance (control total basis):			
(Deficit) for the year		(3,353)	(10,098)
Remove net impairments not scoring to the Departmental expenditure limit		(1,655)	2,681
Remove impact of capital grants and donations		(574)	247
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(155)	-
Adjusted financial performance (deficit)		**(5,737)**	**(7,170)**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	14	3,314	4,009
Property, plant and equipment	15	202,276	189,572
Receivables	19	338	-
Total non-current assets		**205,928**	**193,581**
Current assets			
Inventories	18	85	81
Receivables	19	19,423	20,509
Non-current assets for sale and assets in disposal groups	20	1,818	1,818
Cash and cash equivalents	21	13,281	20,405
Total current assets		**34,607**	**42,813**
Current liabilities			
Trade and other payables	22	(33,366)	(34,904)
Borrowings	24	(5,421)	(400)
Provisions	26	(453)	(2,441)
Other liabilities	23	(5,654)	(3,426)
Total current liabilities		**(44,894)**	**(41,171)**
Total assets less current liabilities		**195,641**	**195,223**
Non-current liabilities			
Borrowings	24	(15,290)	(15,708)
Provisions	26	(557)	(262)
Total non-current liabilities		**(15,847)**	**(15,970)**
Total assets employed		**179,794**	**179,253**
Financed by			
Public dividend capital		93,158	89,292
Revaluation reserve		55,551	55,523
Other reserves		(755)	(755)
Income and expenditure reserve		31,840	35,193
Total taxpayers' equity		**179,794**	**179,253**

The notes on pages A5 to A44 form part of these accounts.



Signed ……
Name **Dr Nick Broughton**
Job title Chief Executive
Date 2 June 2020

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**89,292**	**55,523**	**(755)**	**35,193**	**179,253**
Surplus/(deficit) for the year	-	-	-	(3,353)	**(3,353)**
Impairments	-	(6,613)	-	-	**(6,613)**
Revaluations	-	6,641	-	-	**6,641**
Public dividend capital received	3,866	-	-	-	**3,866**
Taxpayers' and others' equity at 31 March 2020	**93,158**	**55,551**	**(755)**	**31,840**	**179,794**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**89,120**	**52,304**	**(755)**	**45,291**	**185,960**
Surplus/(deficit) for the year	-	-	-	(10,098)	**(10,098)**
Impairments	-	(903)	-	-	**(903)**
Revaluations	-	4,122	-	-	**4,122**
Public dividend capital received	172	-	-	-	**172**
Taxpayers' and others' equity at 31 March 2019	**89,292**	**55,523**	**(755)**	**35,193**	**179,253**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

PDC Capital was received this year:
£3,000k towards the refurbishment of Austen House, a low secure Children and Young People Mental Health facility;
£414k for improvements to the high dependency unit in Leigh House;
£227k for provider digitisation; and
£225k for additional store and forward capabilities on the electronic patient record system.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
These represent the net asset balances of demised organisations or functions which have previously merged into Southern Health NHS Foundation Trust accounts. The last significant entry being in 2012/13.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		2,290	(3,920)
Non-cash income and expense:			
Depreciation and amortisation	6.1	8,452	8,876
Net impairments	7	(1,655)	2,681
Income recognised in respect of capital donations	4	(825)	(16)
Decrease / (increase) in receivables and other assets *	19.1	432	(1,923)
(Increase) in inventories	18	(4)	(60)
Increase in payables and other liabilities **	22.1 & 23	186	2,661
(Decrease) / increase in provisions	26.1	(1,693)	1,850
Net cash flows from operating activities		**7,183**	**10,149**
Cash flows from investing activities			
Interest received	11	281	183
Purchase of intangible assets	14.1	(922)	(1,440)
Purchase of PPE and investment property	15.1	(17,440)	(9,967)
Sales of PPE and investment property	13	21	3
Receipt of cash donations to purchase assets	16	825	16
Net cash flows (used in) investing activities		**(17,235)**	**(11,205)**
Cash flows from financing activities			
Public dividend capital received	SOCIE	3,866	172
Movement on loans from DHSC	24.2	5,000	-
Capital element of finance lease rental payments	24.3	-	(1)
Capital element of PFI, LIFT and other service concession payments	24.2	(400)	(400)
Other interest	12.1	-	(1)
Interest paid on finance lease liabilities	24.2	(4)	(4)
Interest paid on PFI, LIFT and other service concession obligations	12.1	(1,205)	(1,191)
PDC dividend (paid)	12.3	(4,329)	(5,392)
Net cash flows from / (used in) financing activities		**2,928**	**(6,817)**
(Decrease) in cash and cash equivalents		**(7,124)**	**(7,873)**
Cash and cash equivalents at 1 April		**20,405**	**28,278**
Cash and cash equivalents at 31 March	21	**13,281**	**20,405**

* This balance excludes PDC dividend receivable per Note 19.

** This balance is adjusted for the change in capital creditors and excludes PDC Dividend payable within Payables Note 22.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

Note 1.2 Material uncertainty relating to going concern

These accounts have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management intends, or has no alternative but, to apply to the Secretary of State for the Trust's dissolution without the transfer of its services to another entity.

The Trust reported a deficit (on a control total basis) of £5.7m for 2019/20, an adverse variance of £6.3m to the revised control total of £0.6m surplus. During 2019/20 the Trust successfully secured revenue support, in the form of a loan, of £5m which enabled the year end cash balances to be higher than planned.

For 2020/21 the Trust had originally planned an agreed deficit within the Hampshire and Isle of Wight Integrated Care System which required £11.4m of support from NHS Improvement to be provided to enable a breakeven position. On top of this there was the need for a challenging cost improvement plan which, within the context of responding to Covid-19, would be more difficult to deliver. Although there is an ongoing national commitment to Trusts who are in difficulties with cash, this is applied for and approved in year when the need arises.

Following the declaration of the pandemic, revised financial arrangements were put in place by NHS Improvement / England to support the sector's response to Covid-19. This has resulted in the 2020/21 operating plan and contract negotiations with Commissioners being paused, increased flexibility on cash and no requirement to pay back loans previously agreed as revenue support. The Trust has set a financial budget for the year based on a refreshed draft plan and demonstrates a planned breakeven position. Key to this plan are the following assumptions:

- That all Covid-19 related expenditure is reimbursed;
- That the financial arrangements in place for income between April and October continue until March 2021 that include, where required, a monthly top up to breakeven or alternative arrangements that achieve the same;
- That identified CIP schemes, where they do not compromise the organisation's response to Covid-19, are implemented;
- That quality improvement schemes such as the reduction in out of area placements will continue at pace to ensure that spend in these areas is reduced to levels below 2019/20;
- A recurrent recovery plan for 2021/22 to be developed aligned to system requirements, linked to reasonable income assumptions from Commissioners for 2021/22, taking account of the ongoing Covid-19 response and future pressures and ways of delivering services;
- Capital schemes for the Trust will be managed within £10.2m (limited by the financial envelopes allocated to the Hampshire and Isle of Wight Integrated Care System) and local cash restraints;
- Planned closing cash balance of £9.5m at the end of June 2021 which demonstrates adequate cash resources through to this date; and
- Continued commitment from the Secretary of State to provide cash support when organisations require it to maintain adequate liquidity.

In accordance with IAS 1, the Directors have made an assessment of the Trust's ability to continue as a going concern considering the significant challenges described above. These factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. The Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. This is supported by the "Statement to Support Forecasting" issued by NHS England and NHS Improvement on 27 May 2020. For this reason, they continue to adopt the going concern basis in preparing the accounts and the financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern

Note 1.3 Interests in other entities

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits, are classified as subsidiaries and are consolidated.

Southern Health NHS Foundation Trust is the Corporate Trustee of Southern Health General Fund ("brighterway"). The charity is deemed to be a subsidiary under the prescriptions of IAS 27. International Accounting Standards dictate that consolidated accounts should be prepared. IAS 1, Presentation of accounts, however, states that specific disclosure requirements to be set out in individual standards or interpretations need not be satisfied if the information is not material. Furthermore, accounting policies set out in IFRS need not be developed or applied if the impact of applying them would be immaterial.

Note 1.3 Interests in other entities (continued)

Whilst Southern Health NHS Foundation Trust does have a connected Charitable Fund, it does not deem this fund material within the context of the accounts of the NHS Foundation Trust. A limited disclosure is therefore contained within note 2 of these accounts and full consolidation has not been undertaken.

Southern Health NHS Foundation Trust is the sole beneficiary of the Southern Health General Fund. The charity registration number is 1089307 and the registered address is as per note 35. Accounts for the charity can be obtained from www.charity-commission.gov.uk.

The Willow Group Partnership is a group of four GP practices who hold the contract with NHS England to supply the primary care services for specific localities in South East Hampshire. This work is then subcontracted to the Foundation Trust who employs the practice staff and underwrite the associated risks. The Trust controls the activities of the Partnership through Senior Managers of the Trust and is recorded as a related party.

Whilst Southern Health NHS Foundation Trust has control of this partnership which would be deemed a subsidiary under IAS 27 similar to the Charitable Fund, they have been deemed to be immaterial in 2019/20 for the preparation of group accounts. Furthermore, it is felt that the additional information of group accounts would not enhance the readers understanding of the NHS Foundation Trust's financial results as the financial impact of these activities are already incorporated within the financial transactions of the Trust as funding is received by Southern Health NHS Foundation Trust from Primary Care Commissioners and pay incurred on behalf of the partnership. A limited disclosure is contained within Note 2.

Note 1.4 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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.
Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract and are recognised through the passage of time.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. Where the projects cover more than one year but relate to one performance obligation and it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

Note 1.4 Revenue from contracts with customers (continued)

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. Income earned from the funds is accounted for as variable consideration.

Note 1.5 Other forms of income

Grants and donations

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. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 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

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 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.

Note 1.8 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 Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has a cost of at least £5,000, or
• collectively, a number 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, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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 lives.

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

Measurement

Valuation

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Professional valuations are carried out by the Valuation Office Agency. The valuations are carried out in accordance with the RICS Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of NHS Improvement and HM Treasury.

Note 1.8 Property, plant and equipment (continued)

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful 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.

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

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 as a reduction to operating expenses.

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

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

Impairments

In accordance with the 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 of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The asset is available for immediate sale in its present condition and the transaction must be highly probable i.e. :

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and 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.

Note 1.8 Property, plant and equipment (continued)

Local Improvement Finance Trust (LIFT) transactions

LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

The NHS Foundation Trust assumed management control of a LIFT procured inpatient facility during April 2010. This is deemed to satisfy the tests of IFRIC 12 and thus has been accounted for by the NHS Foundation Trust as a PFI asset which is disclosed within the Statement of Financial Position. Note 30 provides further details.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	-	74
Dwellings	25	25
Plant & machinery	-	10
Transport equipment	7	7
Information technology	5	5
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the 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 Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

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

Expenditure on research is not capitalised.
Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, e.g. 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, e.g. application software, is capitalised as an intangible asset.

Note 1.9 Intangible assets (continued)

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.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

De-recognition

When intangible assets have been assessed as obsolete, replaced or reached the end of their useful lives they are de-recognised from the accounts.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Development expenditure	5	5
Software licences	5	5

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 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, i.e. when receipt or delivery of the goods or services is made.

Note 1.12 Financial assets and financial liabilities (continued)

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 and liabilities are classified as subsequently measured at amortised cost, fair value through income and expenditure.

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 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).

The Trust assess the credit losses on a debt class basis, the categories being Non NHS receivables and Individuals. Recent performance of collectability is calculated and applied to that class of debt. Credit losses are not expected with other NHS bodies due to the agreement of balances exercise and subsequent reporting within consolidated group accounts.

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.

Derecognition

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

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

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

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

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

The annual rental charge 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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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.

The Trust as a lessor

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Southern Health NHS Foundation Trust receives no amounts from lessees under finance leases.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of 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 HM Treasury's discount rates effective for 31 March 2020:

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 26.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

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

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

In accordance with the requirements laid down by the Department of Health and Social Care (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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

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

Note 1.18 Corporation tax

The NHS Foundation Trust is not liable for corporation tax for the following reasons:
- private patient activities are covered by section 14(1) of the Health and Social Care (Community Health and Standards) Act 2003 and are not treated as a commercial activity and are therefore tax exempt; and
- other trading activities, for example staff canteens are ancillary to core activities and are not deemed to be entrepreneurial in nature.

Note 1.19 Foreign exchange

The NHS Foundation Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Given the insignificant number and immaterial value of foreign currency transactions processed through the year, the NHS Foundation Trust has not re-translated monetary assets and liabilities to 31 March 2020 or 31 March 2019 spot exchange rates. No exchange rate gains or losses are therefore recognised in the NHS Foundation Trust's (deficit)/surplus for the year then ended.

Note 1.20 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.21 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 Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

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 remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The 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 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. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.
For leases commencing in 2021/22, the 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.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 1.24 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:
Other than the valuation of non-current assets, there are no key assumptions for 2019/20 concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

In accordance with Note 1.8 the NHS Foundation Trust's land and buildings have been subject to a desktop good housekeeping review by the Valuation Office Agency in January 2020 except for two properties, Austen House and Parklands Hospital which have been subject to major capital improvement in the prior and current period and therefore physically inspected. The effect of these valuations are recorded in note 15.

The NHS Foundation Trust has obtained the valuation for specialised assets based on the optimised modern equivalent asset assumption as suggested in IAS16. In practical terms, this means assessing if
- the location of the services could be moved to a more cost effective locality
- the building layout is inefficient, what would the floor space be in order to deliver the same services
- the building footprint reduced, could the land area reduce accordingly

The main purpose of this exercise was to ensure that the carrying values of the estate fairly reflected how the NHS Foundation Trust could deliver the services if the Trust had a blank canvas to start from.
Although the MEA assumptions used in the NHS Foundation Trust's estate valuation process have been developed by a senior member of the Trust's estates team and the Valuation Office Agency, there is inherent uncertainty in the assumptions given the nature of optimising a complex and varied specialised portfolio of assets.

The valuation exercise was carried out as at January 2020 applying indices for March 2020 which were available by the time the valuation was prepared. Given the events between January 2020 and March 2020, we requested the valuer to provide an update to the valuation. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 and RICS UK National Supplement commonly known together as the Red Book, the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. Consequently, less certainty and a higher degree of caution should be attached to the valuation than would normally be the case. The 'material valuation uncertainty' is not meant to suggest that the valuation cannot be relied upon; rather, 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.

There has been no diminution identified in the Trust’s ongoing requirement for these operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of Covid-19.

Regarding the BCIS cost indices, BCIS have stated that they consider new construction output is likely to fall in 2020 as a result of the Covid-19 outbreak, as it affects labour availability on sites and delays or leads to cancellation of projects in the pipeline. However, at the present time, BCIS have advised and the Valuation Office Agency agree that it is too early for Covid-19 related issues to impact on BCIS indices published and adopted in the valuations.

The BICS cost indices are comprised of the market conditions relating to labour, materials and a location factor. The change in these from year to year are used to inform the revaluation exercise which can result in increases and decreases to the carrying value of the buildings valued using depreciated replacement cost.

Whilst 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. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements.
The valuation of the land is assessed as £41,643k and buildings as £142,224k. The impact of Covid-19 cannot be quantified but to give an example, a 10% variance to the valuation could mean an impact of £18,386k to the statement of financial position and a change in PDC Dividends cost of £321k.

Note 2 Operating Segments and Subsidiaries

Note 2.1 Segmental Reporting

IFRS8 requires an entity to report financial performance within its accounts in the same format to that received on a regular basis by the 'Chief Operating Decision maker' of the entity. During 2019/20 the Trust has reported to its Board financial performance at a divisional level on a highly summarised basis, being budget vs. actual for the year, cumulatively and year end forecast. As Board decisions are not being made using the divisional data, for the purpose of the 2019/20 accounts, Southern Health considers that it operates a single segment, 'healthcare', and segmental disclosures therefore do not need to be produced.

Note 2.2 Southern Health NHS Foundation Trust Charitable Fund

The accounts of the NHS Foundation Trust's charitable fund, whilst not operated at arm's length to the NHS Foundation Trust, have not been consolidated within these accounts in accordance with IAS 27 for the reasons described in Note 1.3.

Whilst the separate accounts for the charitable fund are available on request, the draft accounts for the year ended 31 March 2020 are summarised below.

Charity's Statement of Financial Activities	**Unaudited 2019/20 £000**	**Audited 2018/19 £000**
Total incoming resources	738	117
Cash resources expended	(1,057)	(207)
Net outgoing resources	**(319)**	**(90)**
(Loss)/Gain on revaluation and disposal plus other fund movements	(12)	15
Net movement in funds	**(331)**	**(75)**

Charity's Balance Sheet (Statement of Financial Position)	**Unaudited 31 March 2020 £000**	**Audited 31 March 2019 £000**
Investments	556	768
Total fixed assets	**556**	**768**
Cash	11	96
Other current assets	-	25
Current liabilities	(42)	(33)
Net assets	**525**	**856**
Restricted / endowment funds	245	543
Unrestricted funds	280	313
Total charitable funds	**525**	**856**

Note 2.3 Willow Group Partnership

As detailed in Note 1.3 the Willow Group Partnership has responsibility for delivering primary care services from four locations in Gosport. The results below are incorporated into Southern Health NHS Foundation Trust financial statements in full.

Memorandum Information included in the Trust's Accounts in respect of the GP Partnership

	2019/20 £000	**2018/19 £000**
Clinical Income	5,727	5,528
Non Clinical Income	141	76
Non Pay Costs	(1,407)	(1,251)
Pay Costs	(4,971)	(5,015)
Net Primary Care Expenditure	**(510)**	**(662)**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2019/20	2018/19
	£000	£000
Mental health services		
Block contract income	157,673	147,988
Clinical income for the secondary commissioning of mandatory services	552	539
Other clinical income from mandatory services	1,985	1,408
Community services		
Community services income from CCGs and NHS England	114,098	109,669
Income from other sources (e.g. local authorities)	27,126	29,021
All services		
Private patient income	3	27
Agenda for Change pay award central funding*	-	3,325
Additional pension contribution central funding**	9,670	-
Other clinical income	937	-
Total income from activities	**312,044**	**291,977**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into the tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts, impacting Notes 6.1 and 8.

Note 3.2 Income from patient care activities (by source)

	2019/20	2018/19
Income from patient care activities received from:	**£000**	**£000**
NHS England	49,157	38,763
Clinical commissioning groups	229,102	216,947
Department of Health and Social Care	-	3,325
Other NHS providers	7,137	4,844
Local authorities	20,300	22,109
Non-NHS: private patients	3	27
Injury cost recovery scheme	142	97
Non NHS: other	6,203	5,865
Total income from activities	**312,044**	**291,977**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2019/20	2018/19
	£000	£000
Income recognised this year	-	-

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,530	-	**1,530**	1,206	-	**1,206**
Education and training	8,080	407	**8,487**	8,788	233	**9,021**
Non-patient care services to other bodies	477	-	**477**	351	-	**351**
Provider sustainability fund (PSF)	2,648	-	**2,648**	4,207	-	**4,207**
Financial recovery fund (FRF)	1,539	-	**1,539**	-	-	**-**
Income in respect of employee benefits accounted for on a gross basis	2,208	-	**2,208**	2,072	-	**2,072**
Receipt of capital grants and donations	-	825	**825**	-	16	**16**
Charitable and other contributions to expenditure	-	17	**17**	-	15	**15**
Rental revenue from operating leases	-	3,058	**3,058**	-	3,004	**3,004**
Other income	4,515	-	**4,515**	3,900	-	**3,900**
Total other operating income	**20,997**	**4,307**	**25,304**	**20,524**	**3,268**	**23,792**

Source of the material amounts within other operating income: Health Education England £8,077k (2018/19 £8,513k).

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	2,267	1,372

Note 5.2 Transaction price allocated to remaining performance obligations

The Trust has no remaining performance obligations that exceed more than one year or accounts for partially completed spells, (2018/19 nil).

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2019/20	2018/19
	£000	£000
Income from services designated as commissioner requested services	308,462	282,311
Income from services not designated as commissioner requested services	3,582	9,666
Total	**312,044**	**291,977**

Note 6.1 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	6,349	6,459
Purchase of healthcare from non-NHS and non-DHSC bodies	16,628	14,582
Staff and executive directors costs	247,592	224,599
Remuneration of non-executive directors	169	141
Supplies and services - clinical (excluding drugs costs)	7,700	7,275
Supplies and services - general	7,217	7,317
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	4,348	4,349
Consultancy costs	59	110
Establishment	5,341	5,106
Premises	8,284	8,196
Transport (including patient travel)	4,183	4,114
Depreciation on property, plant and equipment	6,908	7,111
Amortisation on intangible assets	1,544	1,765
Net impairments	(1,655)	2,681
Movement in credit loss allowance: contract receivables / contract assets	253	(28)
Audit fees payable to the external auditor		
audit services- statutory audit	111	96
other auditor remuneration (external auditor only)	-	10
Internal audit costs	123	120
Clinical negligence	1,317	1,859
Legal fees	408	518
Insurance	282	279
Education and training	1,155	1,271
Rentals under operating leases	12,796	15,749
Early retirements	4	4
Redundancy	35	(83)
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,271	1,176
Car parking & security	289	295
Hospitality	74	77
Losses, ex gratia & special payments	103	6
Other services, e.g. external payroll	3,102	2,156
Other	(932)	2,379
Total	**335,058**	**319,689**

Within the Staff and executive directors costs is the additional 6.3% of Employers Pension contributions mentioned in Note 3.1 of £9,670k.

Within other spend there is the reversal of provisions for costs charged in the prior year which are no longer required, £1,362k.

Note 6.2 Other auditor remuneration

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	-	10
Total	**-**	**10**

The change in fees is due to the Covid-19 related reduction to the quality report requirements for 2019/20.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

Note 7 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	161	2,681
Other	(1,816)	-
Total net impairments charged to operating surplus / deficit	**(1,655)**	**2,681**
Impairments charged to the revaluation reserve	6,613	903
Total net impairments	**4,958**	**3,584**

Austen House was reopened in October 2019 following a major refurbishment exercise to convert the facility into a low secure Children and Young Peoples mental health facility. The reversal of a prior impairment for £1,816k has been processed following an increase in value due to the building improvements that have been made.

The revaluation exercise performed in January 2020 reduced the carrying value of a number of properties in the Trust's portfolio. The BCIS indices is broadly comprised of the cost of labour and materials plus a location factor which are used to recreate the assets using current prices. The location factor for this year has reduced by 6.7%.

The overall effect of the review was a net downwards valuations of £4,958k offset by an increase in valuations on other properties of £6,641k (Note 17) an overall increase of £1,683k on an asset base at the end of the year of £186,023k, 0.9%.

Note 8 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	172,758	166,783
Social security costs	16,438	15,896
Apprenticeship levy	841	812
Employer's contributions to NHS pensions (See Note 6.1)	31,799	21,422
Pension cost - other	62	27
Termination benefits	-	633
Temporary staff (including agency)	26,802	20,117
Total gross staff costs	**248,700**	**225,690**
Of which		
Costs capitalised as part of assets	1,073	1,174

Reconciliation of staff related costs in Note 6.1 Operating Expenses	**2019/20 £000**	**2018/19 £000**
Employee expenses	247,592	224,599
Redundancy	35	(83)
Costs capitalised as part of assets and not included in Note 6.1	1,073	1,174
Total gross staff costs	**248,700**	**225,690**

Note 8.1 Retirements due to ill-health

During 2019/20 there were 3 early retirements from the Trust agreed on the grounds of ill-health (11 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £175k (£514k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 8.2 Directors Remuneration

The aggregate amounts payable to directors were:

	2019/20 £000	2018/19 £000
Salary	1,132	1,023
Taxable benefits	8	37
Employer's pension contributions	77	107
Payment in Lieu of Notice	29	-
Total	**1,246**	**1,167**

Further details of directors' remuneration can be found in the remuneration report.
There are no long term incentives schemes, other pension benefits, guarantees and advances for directors of the NHS Foundation Trust.

Note 9 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:

a) 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 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.

b) 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 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 at 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 judgement 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)

In 2019/20 the Trust continued its participation of the National Employment Savings Trust (NEST) which is a defined contribution workplace pension scheme. The scheme is in use for a small number of staff as an alternative to the NHS Pension Scheme. Employer and employee contributions for the year totalled £144k (2018/19 £62k). There is no upper limit on annual contributions per scheme participant. NEST is a scheme set up by government to enable employers to meet their pension duties, and is free for employers to use. Members pay a 1.8% charge on contributions plus an annual management charge of 0.3%.

Note 10 Operating leases

Note 10.1 Southern Health NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Southern Health NHS Foundation Trust is the lessor.

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	3,058	3,004
Total	**3,058**	**3,004**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	3,039	2,789
- later than one year and not later than five years;	471	463
- later than five years.	256	221
Total	**3,766**	**3,473**

Note 10.2 Southern Health NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Southern Health NHS Foundation Trust is the lessee.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	12,954	15,749
Less sublease payments received	(158)	-
Total	**12,796**	**15,749**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	12,961	12,385
- later than one year and not later than five years;	41,969	40,383
- later than five years.	7,556	17,324
Total	**62,486**	**70,092**
Future minimum sublease payments to be received	(517)	(634)

The NHS foundation Trust leases:
25 properties from NHS Property Services Ltd with a total future commitment of £39,400k, (2018/19 £58,000k). There was an assumed occupancy of 6 years in 2018/19 therefore there is an estimated 5 year remaining lease term for these properties.

4 properties from Community Health Partnerships Ltd with a future commitment of £6,700k, (2018/19 £8,400k).

Other significant operating lease commitments for properties with other landlords are: Avalon House £2,994k to December 2029, (2018/19 £3,297k), revised lease Black Horse House £2,700k to February 2024, (2018/19 £317k), Stoke Road Medical Centre £2,653k to April 2032, (2018/19 £2,871k), and the Parkway Centre £1,910k to February 2030, (2018/19 £2,521k).

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	281	183
Total finance income	**281**	**183**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	3	-
Finance leases	4	4
Interest on late payment of commercial debt	-	1
Main finance costs on PFI and LIFT schemes obligations	846	868
Contingent finance costs on PFI and LIFT scheme obligations	359	323
Total interest expense	**1,212**	**1,196**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20	2018/19
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	1

Note 12.3 PDC Dividend Cash Movements

	2019/20	2018/19
	£000	£000
PDC Dividends Receivable at April	(316)	(92)
Charge for the Year	4,733	5,168
PDC Dividends (payable) / receivable at March	(88)	316
PDC Dividends Paid in year	**4,329**	**5,392**

Note 13 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	24	5
Losses on disposal of assets	(3)	(2)
Total gains / (losses) on disposal of assets	**21**	**3**

The gain on disposal relates to the CT Scanner disposed of in the year.

Note 14.1 Intangible assets - 2019/20

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**2,520**	**6,748**	**327**	**9,595**
Additions	228	580	41	**849**
Reclassifications	27	319	(346)	**-**
Disposals / derecognition	(140)	(1,572)	-	**(1,712)**
Valuation / gross cost at 31 March 2020	**2,635**	**6,075**	**22**	**8,732**
Amortisation at 1 April 2019	**1,042**	**4,544**	**-**	**5,586**
Provided during the year	489	1,055	-	**1,544**
Disposals / de-recognition	(140)	(1,572)	-	**(1,712)**
Amortisation at 31 March 2020	**1,391**	**4,027**	**-**	**5,418**
Net book value at 31 March 2020	**1,244**	**2,048**	**22**	**3,314**
Net book value at 31 March 2019	**1,478**	**2,204**	**327**	**4,009**

Note 14.2 Intangible assets - 2018/19

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018	**2,310**	**6,346**	**281**	**8,937**
Additions	170	402	197	**769**
Reclassifications	41	110	(151)	**-**
Disposals / derecognition	(1)	(110)	-	**(111)**
Valuation / gross cost at 31 March 2019	**2,520**	**6,748**	**327**	**9,595**
Amortisation at 1 April 2018	**572**	**3,360**	**-**	**3,932**
Provided during the year	471	1,294	-	**1,765**
Disposals / derecognition	(1)	(110)	-	**(111)**
Amortisation at 31 March 2019	**1,042**	**4,544**	**-**	**5,586**
Net book value at 31 March 2019	**1,478**	**2,204**	**327**	**4,009**
Net book value at 31 March 2018	**1,738**	**2,986**	**281**	**5,005**

Note 15.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019	**37,323**	**140,075**	**455**	**6,648**	**7,000**	**113**	**7,739**	**502**	**199,855**
Additions	-	7,985	-	6,924	1,366	-	1,431	223	**17,929**
Impairments	(100)	(7,172)	-	-	-	-	-	-	**(7,272)**
Reversals of impairments	221	765	-	-	-	-	-	-	**986**
Revaluations	4,199	(629)	-	-	-	-	-	-	**3,570**
Reclassifications	-	4,501	-	(4,675)	91	-	69	14	**-**
Disposals / derecognition	-	(50)	-	-	(646)	(29)	(2,266)	(14)	**(3,005)**
Valuation/gross cost at 31 March 2020	**41,643**	**145,475**	**455**	**8,897**	**7,811**	**84**	**6,973**	**725**	**212,063**
Accumulated depreciation at 1 April 2019	**-**	**1,371**	**2**	**-**	**4,140**	**83**	**4,449**	**238**	**10,283**
Provided during the year	-	4,608	18	-	1,037	12	1,167	66	**6,908**
Reversals of impairments	-	(1,328)	-	-	-	-	-	-	**(1,328)**
Revaluations	-	(3,053)	(18)	-	-	-	-	-	**(3,071)**
Disposals / de-recognition	-	(50)	-	-	(646)	(29)	(2,266)	(14)	**(3,005)**
Accumulated depreciation at 31 March 2020	**-**	**1,548**	**2**	**-**	**4,531**	**66**	**3,350**	**290**	**9,787**
Net book value at 31 March 2020	**41,643**	**143,927**	**453**	**8,897**	**3,280**	**18**	**3,623**	**435**	**202,276**
Net book value at 31 March 2019	**37,323**	**138,704**	**453**	**6,648**	**2,860**	**30**	**3,290**	**264**	**189,572**

Note 15.2 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018	**35,975**	**139,559**	**455**	**2,383**	**7,226**	**113**	**8,132**	**717**	**194,560**
Additions	-	2,386	-	6,303	284	-	780	25	**9,778**
Impairments	(375)	(3,843)	-	-	-	-	-	-	**(4,218)**
Reversals of impairments	200	70	-	-	-	-	-	-	**270**
Revaluations	1,523	-	-	-	-	-	-	-	**1,523**
Reclassifications	-	1,951	-	(2,038)	6	-	80	1	**-**
Disposals / derecognition	-	(48)	-	-	(516)	-	(1,253)	(241)	**(2,058)**
Valuation/gross cost at 31 March 2019	**37,323**	**140,075**	**455**	**6,648**	**7,000**	**113**	**7,739**	**502**	**199,855**
Accumulated depreciation at 1 April 2018	**-**	**-**	**-**	**-**	**3,529**	**67**	**4,175**	**422**	**8,193**
Provided during the year	-	4,367	17	-	1,127	16	1,527	57	**7,111**
Impairments	-	(364)	-	-	-	-	-	-	**(364)**
Revaluations	-	(2,584)	(15)	-	-	-	-	-	**(2,599)**
Disposals / derecognition	-	(48)	-	-	(516)	-	(1,253)	(241)	**(2,058)**
Accumulated depreciation at 31 March 2019	**-**	**1,371**	**2**	**-**	**4,140**	**83**	**4,449**	**238**	**10,283**
Net book value at 31 March 2019	**37,323**	**138,704**	**453**	**6,648**	**2,860**	**30**	**3,290**	**264**	**189,572**
Net book value at 31 March 2018	**35,975**	**139,559**	**455**	**2,383**	**3,697**	**46**	**3,957**	**295**	**186,367**

Note 15.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	41,643	125,435	453	8,897	2,279	18	3,551	435	**182,711**
Finance leased	-	328	-	-	-	-	-	-	**328**
On-SoFP PFI contracts and other service concession arrangements	-	17,522	-	-	-	-	-	-	**17,522**
Owned - donated	-	642	-	-	1,001	-	72	-	**1,715**
NBV total at 31 March 2020	**41,643**	**143,927**	**453**	**8,897**	**3,280**	**18**	**3,623**	**435**	**202,276**

Note 15.4 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	37,323	119,746	453	6,648	2,486	30	3,192	264	**170,142**
Finance leased	-	328	-	-	-	-	-	-	**328**
On-SoFP PFI contracts and other service concession arrangements	-	18,037	-	-	-	-	-	-	**18,037**
Owned - donated	-	593	-	-	374	-	98	-	**1,065**
NBV total at 31 March 2019	**37,323**	**138,704**	**453**	**6,648**	**2,860**	**30**	**3,290**	**264**	**189,572**

Note 16 Donations of property, plant and equipment

The Friends of Lymington New Forest Hospital contributed £575k and brighterway, the charity for Southern Health NHS Foundation Trust donated £250k to jointly purchase a new CT Scanner in the year, £825k. (2018/19 £16k for frailty medical equipment from brighterway).

Note 17 Revaluations of property, plant and equipment

	2019/20	2018/19
	£000	£000
Revaluation at 1 April	55,523	52,304
Impairments	(6,613)	(903)
Revaluations	6,641	4,122
Revaluation at 31 March	**55,551**	**55,523**

The valuation this year was a desktop and good housekeeping review with the exception of physical inspections that were needed where major capital improvements had taken place, namely Austen House and Parklands Hospital.
- the effective date of the most recent valuation is 31 January 2020 using the March 2020 indices which were available by the time the valuation was prepared;
- the valuation was carried out by RICS qualified independent valuer;
- the assets valuation basis is either Specialised and Non Specialised properties;
- the estimated remaining lives are assessed as part of the valuation; and
- modern equivalent asset basis has been applied to specialised property where deemed appropriate.

The upwards revaluations mainly related to the greater utilisation of the estate, notably at Alton Hospital, the Bridge Centre and Austen House.

Note 18 Inventories

	31 March 2020 £000	31 March 2019 £000
Consumables and Drugs	85	81
Total inventories	**85**	**81**

Note 19.1 Trade and other receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	14,282	16,039
Allowance for impaired contract receivables / assets	(492)	(246)
Prepayments (non-PFI)	1,629	1,917
PDC dividend receivable	-	316
VAT receivable	3,943	2,461
Other receivables	61	22
Total current receivables	**19,423**	**20,509**
Non-current		
Other receivables	338	-
Total non-current receivables	**338**	**-**
Of which receivable from NHS and DHSC group bodies:		
Current	13,468	15,129
Non-current	338	-

During 2019/20, a national initative was created by the NHS for clinicians who were facing large tax liabilities as a result of changes to the HMRC allowance limits arising from their NHS Pension. The contractually binding scheme ensures that when the clinician retires the tax impact for 2019/20 will be fully compensated by the Trust as the NHS employer.

The cost of this scheme will ultimately be met by NHS England, or their successor, so does not impact the Trust's financial position. To account for this arrangement, non-current provisions (Note 26) have been recognised as Southern Health NHS Foundation Trust will need to reimburse the clinician in the future and a non current receivable has been recognised which will be settled by NHS England as and when the need occurs.

Note 19.2 Allowances for credit losses

	2019/20	2018/19	
	Contract receivables and contract assets	Contract receivables and contract assets	All other receivables
	£000	£000	£000
Allowances as at 1 April	**246**	**-**	**1,143**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-	326	(1,143)
New allowances arising	362	73	-
Changes in existing allowances	(55)	4	-
Reversals of allowances	(54)	(105)	-
Utilisation of allowances (write offs)	(7)	(52)	-
Allowances as at 31 March 2020	**492**	**246**	**-**

Note 20 Non-current assets held for sale and assets in disposal groups

	2019/20	2018/19
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,818**	**1,818**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**1,818**	**1,818**

Work is continuing to complete the sale for the associated property during 2020/21.

Note 21 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2019/20	2018/19
	£000	£000
At 1 April	**20,405**	**28,278**
Net change in year	(7,124)	(7,873)
At 31 March	**13,281**	**20,405**
Broken down into:		
Cash at commercial banks and in hand	81	46
Cash with the Government Banking Service	13,200	20,359
Total cash and cash equivalents as in SoFP	**13,281**	**20,405**
Total cash and cash equivalents as in SoCF	**13,281**	**20,405**

Note 21.1 Third party assets held by the Trust

Southern Health NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Bank balances	145	197
Total third party assets	**145**	**197**

Note 22.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	12,657	16,918
Capital payables	1,784	1,368
Accruals	6,547	7,118
Receipts in advance and payments on account	3,890	1,421
Social security costs	2,460	2,319
Other taxes payable	1,120	1,083
PDC dividend payable	88	-
Other payables	4,820	4,677
Total current trade and other payables	**33,366**	**34,904**
Of which payables from NHS and DHSC group bodies:	7,978	10,762

There are no non-current payables, (2018/19 nil).

Note 23 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Contract liabilities: deferred income:	5,654	3,426
Total other current liabilities	**5,654**	**3,426**

Note 24.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	5,003	-
Obligations under finance leases	1	-
Obligations under PFI, LIFT or other service concession contracts	417	400
Total current borrowings	**5,421**	**400**
Non-current		
Obligations under finance leases	83	84
Obligations under PFI, LIFT or other service concession contracts	15,207	15,624
Total non-current borrowings	**15,290**	**15,708**

The Trust called down an interim loan of £5m from NHS Improvement due to the worsening financial position and subsequent reforecast cash position of the Trust during the year. The scheduled repayment date was in 2023 and would normally be disclosed as non-current borrowings.

However, a decision on 2 April 2020 by the Department of Health and Social Care was made which will result in the issue of Public Dividend Capital so that the DHSC loan can be repaid in September 2020. The timing of this decision makes it an adjusting event after the reporting period and has led to the borrowings to be reclassified as a current loan.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**-**	**84**	**16,024**	**16,108**
Cash movements:				
Financing cash flows - payments and receipts of principal	5,000	-	(400)	**4,600**
Financing cash flows - payments of interest	-	(4)	(846)	**(850)**
Non-cash movements:				
Application of effective interest rate	3	4	846	**853**
Carrying value at 31 March 2020	**5,003**	**84**	**15,624**	**20,711**

Note 24.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**-**	**85**	**16,424**	**16,509**
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(1)	(400)	**(401)**
Financing cash flows - payments of interest	-	(4)	(868)	**(872)**
Non-cash movements:				
Application of effective interest rate	-	4	868	**872**
Carrying value at 31 March 2019	**-**	**84**	**16,024**	**16,108**

Note 25 Finance leases

Note 25.1 Southern Health NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	**200**	**204**
of which liabilities are due:		
- not later than one year;	5	5
- later than one year and not later than five years;	18	18
- later than five years.	177	181
Finance charges allocated to future periods	(116)	(120)
Net lease liabilities	**84**	**84**
of which payable:		
- not later than one year;	1	-
- later than one year and not later than five years;	2	2
- later than five years.	81	82

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2019	**42**	**199**	**2,237**	**225**	**2,703**
Arising during the year	**-**	**65**	**63**	**338**	**466**
Utilised during the year	(6)	(11)	(642)	-	**(659)**
Reversed unused	**-**	**-**	**(1,362)**	**(138)**	**(1,500)**
At 31 March 2020	**36**	**253**	**296**	**425**	**1,010**
Expected timing of cash flows:					
- not later than one year;	5	127	296	**25**	**453**
- later than one year and not later than five years;	20	126	-	**34**	**180**
- later than five years.	11	-	-	**366**	**377**
Total	**36**	**253**	**296**	**425**	**1,010**

There was a partial reversal of the restructuring provision created in the prior year following a redeployment programme within the Trust.

The commitment to fund clinicians' 2019/20 tax cost when they retire is included within the other category, £338k. The Scheme Pays Initiative is described in Note 19.

Note 26.2 Clinical negligence liabilities

At 31 March 2020, £8,382k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Southern Health NHS Foundation Trust (31 March 2019: £9,111k).

Note 27 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(221)	(197)
Gross value of contingent liabilities	**(221)**	**(197)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(221)**	**(197)**
Net value of contingent assets	**-**	**-**

Contingent liabilities are costs that are less than 50% likely and so includes the excess costs for litigation cases where it is believed the NHS Foundation Trust will win.

Note 28 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	1,694	7,647
Total	**1,694**	**7,647**

Note 29 Other financial commitments

The Trust is not committed to making payments under non-cancellable contracts which are not leases, PFI contracts or other service concession arrangement.

Note 30 On-SoFP PFI, LIFT or other service concession arrangements

Southern Health NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position LIFT scheme, Antelope House in Southampton.

Note 30.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**43,078**	**44,596**
Of which liabilities are due		
- not later than one year;	1,641	1,602
- later than one year and not later than five years;	7,486	7,083
- later than five years.	33,951	35,911
Finance charges allocated to future periods	(27,454)	(28,572)
Net PFI, LIFT or other service concession arrangement obligation	**15,624**	**16,024**
- not later than one year;	417	400
- later than one year and not later than five years;	2,269	2,008
- later than five years.	12,938	13,616

Note 30.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**67,428**	**69,859**
Of which payments are due:		
- not later than one year;	2,631	2,562
- later than one year and not later than five years;	11,197	10,903
- later than five years.	53,600	56,394

Note 30.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	**2,567**	**2,500**
Consisting of:		
- Interest charge	846	868
- Repayment of balance sheet obligation	400	401
- Service element and other charges to operating expenditure	772	740
- Revenue lifecycle maintenance	190	168
- Contingent rent	359	323
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	312	316
Total amount paid to service concession operator	**2,879**	**2,816**

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with governmental bodies, the NHS Foundation Trust is not exposed to the degree of financial risk faced by commercial entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The NHS Foundation Trust's treasury management operations are carried out by the finance department with investment advice received as required from Royal London Cash Management (RLCM), within parameters defined formally within the NHS Foundation Trust's standing financial instructions and policies agreed by the Trust Board. Due to the way Department of Health calculates the cost of the 3.5% Trust Dividend which allows an offset for average cleared balances held within the Government Banking Service (GBS), or National Loans Fund deposits, there has been no financial justification for the NHS Foundation Trust to make any investments outside of these two facilities during the current year.

Currency risk

The NHS Foundation Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Foundation Trust has no overseas operations. The NHS Foundation Trust therefore has low exposure to currency rate fluctuations.

Market Risk

100% of the NHS Foundation Trust's financial liabilities carry a nil or fixed rate of interest. The NHS Foundation Trust is not, therefore, exposed to significant interest rate risk.

Credit risk

The NHS Foundation Trust's risk profile is low with the maximum being disclosed in receivables to customers. Note 19.1 provides information on the NHS Foundation Trust's potential credit losses. The NHS Foundation Trust does not enter into derivatives as a financial instrument. The NHS Foundation Trust has reviewed its lease contracts and notes that there are limited credit risks identified. These are deemed to be closely related and therefore are not required to be disclosed separately.

As set out in Note 21, all material balances of the NHS Foundation Trust's £13.3 million (2018/19 £20.4 million) total cash deposits are held in the Government Banking Service's accounts. The NHS Foundation Trust is therefore satisfied that there is no material exposure to credit risk in respect of cash deposits.

Liquidity risk

The NHS Foundation Trust's net operating costs are incurred under annual service agreements with Commissioning Care Groups and NHS England, which are financed from resources voted annually by Parliament. The NHS Foundation Trust also financed its capital expenditure in the year from funds generated from its activities, cash reserves and new issue of Public Dividend Capital.

As mentioned in the going concern note, the financial planning model suggests that the NHS Foundation Trust has sufficient cash to meet its day to day operations throughout 2020/21. Operating cash risks surrounding Covid-19 have been mitigated through NHS England and NHS Improvement's joint response to the pandemic giving assurances to all NHS Providers. This then enables the Trust to satisfy the recently issued Cabinet Office Procurement Policy Notes which support payments to suppliers.

Note 31.2 Carrying values of financial assets

	31 March 2020	31 March 2019
	Held at amortised cost	Held at amortised cost
	£000	£000
Trade and other receivables excluding non financial assets	14,189	15,813
Cash and cash equivalents	13,281	20,405
Total value of financial assets	**27,470**	**36,218**

Note 31.3 Carrying values of financial liabilities

	31 March 2020	31 March 2019
	Held at amortised cost	Held at amortised cost
	£000	£000
Loans from the Department of Health and Social Care	5,003	-
Obligations under finance leases	84	84
Obligations under PFI, LIFT and other service concession contracts	15,624	16,024
Trade and other payables excluding non financial liabilities	25,720	30,081
Provisions under contract	721	2,460
Total at 31 March 2020	**47,152**	**48,649**

Note 31.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	31,462	32,941
In more than one year but not more than two years	373	419
In more than two years but not more than five years	1,932	1,591
In more than five years	13,385	13,698
Total	**47,152**	**48,649**

Note 32 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	-	5	-
Bad debts and claims abandoned	42	12	61	52
Total losses	**43**	**12**	**66**	**52**
Special payments				
Compensation under court order or legally binding arbitration award	6	12	9	46
Ex-gratia payments	23	32	34	167
Total special payments	**29**	**44**	**43**	**213**
Total losses and special payments	**72**	**56**	**109**	**265**
Compensation payments received		-		-

Note 33 Related parties

Southern Health NHS Foundation Trust is an independent public benefit corporation as authorised by Monitor (now part of NHS Improvement).

The related party transactions during 2019/20 and 2018/19 detailed below were related by virtue of the Board member listed along with their role in the third party.

		Receivables		Payables	
		31-Mar-20	31-Mar-19	31-Mar-20	31-Mar-19
		£000	£000	£000	£000
(i)	The Willow Group (Paula Hull, General Partner)	284	9	1	130
(ii)	Southern Health NHS Foundation Trust General Fund Charity Registered No: 1089307 (All directors Trustees of the charity)	37	28	-	-
(iii)	Wessex Academic Health Service Network (Dr Nick Broughton)	-	-	-	-
(iv)	Anglo-European College of Chiropractic (Jeni Bremner)	-	-	-	-
	Total	321	37	1	130

		Income		Expenditure	
		2019/20	2018/19	2019/20	2018/19
		£000	£000	£000	£000
(i)	The Willow Group (Paula Hull, General Partner)	6,088	5,303	43	50
(ii)	Southern Health NHS Foundation Trust General Fund Charity Reg No: 1089307 (All directors Trustees of the charity)	901	132	-	206
(iii)	Wessex Academic Health Service Network (Dr Nick Broughton)	15	22	-	-
(iv)	Anglo-European College of Chiropractic (Jeni Bremner)	-	23	-	-
	Total	7,004	5,480	43	256

(i) The NHS Foundation Trust has entered into a subcontracting arrangement to deliver the Primary Care Services in alliance with the the Willow Group. The values disclosed in this note are for transactions between the Trust and the Partnership which do not benefit Paula Hull personally.

(ii) All expenditure of the charity is for the benefit of the staff and patients of Southern Health NHS Foundation Trust.

(iii) Wessex Academic Health Service Network, Dr Nick Broughton is a board member.

(iv) Anglo-European College of Chiropractic, Jeni Bremner is a Governor.

The Trust had expenditure in 2019/20 relating to Chrysalis (Paul Draycott) and NHS Confederation (Dr Nick Broughton), however these amount to less than £500 and so have not been included in the table above.

All of the transactions listed above and below are unsecured and under no guarantees.

Note 33.1 Related parties

The Department of Health is regarded as a related party. The Trust has had a significant number of transactions with the Department and with other entities for which the Department is regarded as the parent department. This note also includes material transactions with other government departments.

The Transactions relate mainly to the provision of healthcare services and the purchase of services in the ordinary course of business.

	2019/20		2018/19		2019/20		2018/19	
Name	**Expenditure with related party**	**Income from related party**	**Expenditure with related party**	**Income from related party**	**Amounts owed to related party**	**Amounts due from related party**	**Amounts owed to related party**	**Amounts due from related party**
Transactions which exceed £250,000:-	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
NHS Dorset CCG	0	1,410	0	900	0	62	0	288
NHS Fareham And Gosport CCG	50	30,696	67	29,957	0	110	41	659
NHS North East Hampshire and Farnham CCG	25	473	74	218	0	16	0	92
NHS North Hampshire CCG	0	29,797	59	27,507	0	80	29	58
NHS Portsmouth CCG	0	4,384	0	1,660	0	60	23	37
NHS South Eastern Hampshire CCG	36	38,211	67	36,865	12	155	97	707
NHS Southampton CCG	0	30,093	0	28,514	2,542	5	0	472
NHS West Hampshire CCG	43	94,595	86	90,042	2	1,747	172	1,642
Isle of Wight NHS Trust	102	427	123	17	9	51	14	17
Portsmouth Hospitals NHS Trust	2,148	1,083	1,872	1,028	388	98	451	139
Solent NHS Trust	3,053	942	2,652	1,928	484	218	622	447
NHS England	19	43,543	14	43,175	1,080	3,682	1,010	6,659
Health Education England	12	8,077	28	8,552	134	265	16	38
NHS Resolution (formerly NHS Litigation Authority)	1,530	0	2,086	0	0	0	0	0
NHS Improvement (Monitor legal entity)	0	200	0	400	0	0	175	175
NHS Property Services Ltd	7,637	8	10,477	7	1,893	38	5,793	30
Community Health Partnerships	751	2	1,003	0	159	5	353	0
Department of Health	0	473	0	3,529	0	0	0	0
Frimley Health NHS Foundation Trust	21	1,077	58	1,058	12	802	4	518
University Hospital Southampton NHS Foundation Trust	3,827	4,346	3,587	5,699	1,786	1,979	2,236	2,289
Hampshire Hospitals NHS Foundation Trust	2,241	716	2,448	609	431	158	437	94
Oxford Health NHS Foundation Trust	2	3,398	1	65	0	3,295	92	11
Midlands Partnership NHS Foundation Trust	17	576	18	571	107	235	0	174
East London NHS Foundation Trust	83	0	285	0	0	0	285	0
Sussex Partnership NHS Foundation Trust	44	293	138	262	22	26	27	42
South Central Ambulance Service NHS Foundation Trust	262	0	263	0	22	0	62	1
Hampshire County Council	492	20,438	471	22,469	1,696	119	3,014	660
Southampton City Council	69	253	36	569	53	45	167	374
Winchester City Council	479	0	346	0	179	0	92	0
NHS Shared Business Services	413	0	281	0	0	0	0	0
HM Revenue & Customs Other taxes	17,279	0	16,708	0	3,580	0	3,402	0
NHS Pension Scheme	31,799	0	21,422	0	3,045	0	2,896	0
HM Revenue & Customs - VAT	0	0	0	0	0	3,943	0	2,461

Note 34 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment of the loan. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. The outstanding interim loan totalling £5,003 (Note 24) as at 31 March 2020 in these financial statements has been classified as current as it will be repayable within 12 months.

Note 35 Contact Details

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