NHS
Southern Health
NHS Foundation Trust

Annual Report and Accounts
2020/21
Southern Health NHS Foundation Trust






OUR VALUES

Patients & people first

Partnership

Respect

Southern Health NHS Foundation Trust

Annual Report and Accounts 2020/21

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 Ron Shields, Chief Executive

I commenced in post on 8 June 2020 and I was excited to join this organisation that does so much to meet the needs of the people of Hampshire and the Isle of Wight.

It has been a privilege to see at first hand, how Trust staff, Governors, service users and volunteers have responded to the COVID-19 pandemic. There is great sadness at the loss and harm for individuals and families, but there has also been the very best of the NHS and public service values. Individual staff and teams have endeavoured to always ensure that the people in our care are safe and to deliver the best quality care for them.

The Trust increased the capacity of our community hospitals and services. The mental health services quickly altered their ways of working to accommodate the best standards of infection prevention and control within the mental health wards. Teams rapidly adopted new ways of working including undertaking many more engagements and consultations online. Despite the restrictions on movement and on the use of facilities good levels of service were maintained. It was particularly pleasing to see the Trust focus on addressing the inequalities that were so amplified by different communities' experience of COVID-19. We are proud of our role in the successful COVID-19 Vaccination Programme. The Trust was also quick to see the need for future management of Long-COVID and established clinics to meet this new need.

In presenting our evidence to Mr Pascoe's Second Stage Independent Review, the Trust had an opportunity to show the progress it has made and what the Trust does well, but also to reflect on what more we can do.

We are renewing our Strategic Objectives in the light of our experience of the COVID-19 pandemic, and the Health and Care Bill 2021 with the opportunities it will present for integrated approaches to Health and Wellbeing in the places that people live.

It is also pleasing to see the continuing improvement in the Staff Survey results. We are absolutely committed to becoming the best place to work and that being the platform for the very best place to receive care. We are also looking to strengthen our partnerships with Local Authority colleagues, as well as other NHS Providers in the Acute Hospitals and Primary Care. Most importantly, in building our partnerships with the people who use our services, their families and carers.

The Trust has achieved a great deal in the last year and there are exciting opportunities ahead.

Introduction by Lynne Hunt, Chair

The last year has been devastating for so many people and my thoughts are with everyone who has experienced loss or life-changing events as a result of the pandemic. This year has tested our health service like no other, and I express my heartfelt thanks to all the staff at Southern Health for their unwavering commitment to the patients, carers and families we support.

I thank my colleagues on the Trust Board and the Council of Governors; their advice, guidance and leadership has been crucial in enabling the organisation to respond effectively to this crisis. I would also like to thank Lena Samuels, Chair of the Integrated Care System, for her ongoing support to the Trust, along with that from our other partners across Hampshire.

Our commitment to improving the way we involve service users, carers and families continued to develop last year despite these challenges. I have been especially pleased to see the progress made in service user-led audits and standards, which have given us a far richer insight into the experience of our patients. The Working in Partnership Committee, comprised of patient and carer representatives and organisations, continued to go from strength to strength. I have also been delighted to see our Youth Board flourish and help us better hear the voices of young people across Hampshire.

There have been significant improvements in the way the Trust works alongside carers too. Carer awareness training, communications plans and the identification of carer leads across the Trust have all grown in the last year, helping to instil the principles of the Triangle of Care: that the best services are those that involve close collaboration between patients, carers and professionals. During the pandemic, I was also impressed to see virtual carer groups set up to provide additional support to carers and their loved ones through lockdown. There is much for us to do in this area but I am confident that we are moving in the right direction.

Last year saw the departure of Dr Nick Broughton, our previous Chief Executive and I thank him again for the significant changes he brought about in the Trust. Ron Shields, who succeeded Nick last year, has already built upon this progress and steered the organisation through successive waves of COVID-19. Ron's experience working at a system level has been apparent and I am pleased that Southern Health is in a stronger position to represent the role of community and mental health services as part of the emerging Integrated Care System in Hampshire and the Isle of Wight.

I would like to thank Adrian Thorne, who has succeeded Andrew Jackman in year as Lead Governor. He has continued to demonstrate the positive impact that Governors can have. His input to the Quality Improvement programme and his steadfastness in driving forward the Trust's work with carers is to be especially commended.

My ambition is for Southern Health to be led by the people we support so, finally, I would like to thank all the patients, carers, and families who have given their precious time and expertise to be involved in the work of the Trust.

1.2 PERFORMANCE OVERVIEW

The purpose of this overview is to understand Southern Health NHS Foundation Trust, our purpose, key risks and how we have performed during the year.

Who we are and what we do

Southern Health NHS Foundation Trust is the main provider of community health, specialist mental health and learning disabilities services for people across Hampshire.

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 to deliver our vision

Our vision and purpose

We will, together, deliver outstanding treatment and care 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

Southern Health in numbers

This year our staff provided care to 192,742 people (compared to 215,013 in 2019/20) across a population of 1,756,104. We cover a large geographical area and operate from over 300 sites including community hospitals, health centres, inpatient units and community based services.

During 2020/21, the COVID-19 pandemic required us to deliver some of our services very differently, with an increased use of telephone and video appointments where clinically appropriate. We provided 1,317,206 contacts with patients in the community this year, compared to 1,158,426 last year. We also delivered 145,738 outpatient appointments and 187,524 bed days; this compares with 201,044 outpatient appointments and 211,235 bed days in 2019/20. The relative decrease in outpatient appointments and inpatient activity reflected the national directive to reduce, where possible and appropriate, attendance to sites.

We are funded by NHS England, local commissioners and local authorities. Our total income, including the income from Clinical Commissioning Groups was £383m (compared to £337m in 2019/20).

As a Foundation Trust, we have 7,717 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.

Our services cover:

- treatment and support to adults and older people experiencing mental illness
- treatment for adults and young people in secure and specialised settings
- Improving Access to Psychological Therapies (IAPT) 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
- Long-COVID clinics.

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 became Southern Health NHS Foundation Trust following a merger of Hampshire Partnership NHS Foundation Trust and Hampshire Community Healthcare. Although over the years we have provided services over a larger geographical footprint, since 2016/17 we have focussed on the 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 (QI) programme was launched, and our clinical services were restructured into geographical divisions with cross-Hampshire specialist services remaining as a standalone division.

In 2019/20, the Trust achieved an improved overall rating of 'Good' from the CQC, which recognised the progress made to improve the quality and safety of our services.

In February 2020, NHS England/Improvement published an independent report into the care of four patients who died whilst under the care of Trust services between 2012 and 2015, and the subsequent investigations and liaison with the patients' families. This report, authored by Nigel Pascoe QC, found significant failings in the Trust's response at the time (prior to the changes in the leadership of the Trust from 2017), and recommended a public investigative process to determine the extent to which the Trust has improved to date. A series of public hearings took place throughout March and April 2021, chaired by Nigel Pascoe QC, and a final report is due for publication in the summer of 2021.

Since March 2020 the Trust, alongside the wider NHS, has been focussed on delivering an effective response to the COVID-19 pandemic, and continuing to provide the best possible care to patients with the minimum of disruption. This has affected the delivery of some strategic programmes, but it has also brought opportunities to use Quality Improvement approaches to respond these challenges. The pandemic response has also driven transformation. For example, the organisation has significantly accelerated its shift to become more digitally enabled. A number of transformation projects have continued, including the development of new adult mental health wards, improving the clinical environment in older people's mental health settings, and opening a new residential unit for people with learning disabilities. Southern Health has also been a key partner in the delivery of the COVID-19 vaccine programme to health and public sector workers as well as the wider public.

Our strategy

In 2019/20 the Board set out a five-year strategy, with four identified strategic priorities:

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

These strategic priorities define what we will do to deliver our vision. In November 2020 the Board undertook a refresh of the strategy to ensure that this continued to reflect our key areas of focus and to provide more detail on the key deliverables over the remaining three years up to 2023/24.

Overleaf is a diagram showing the four strategic priorities, the identified success factors and the 2023/24 deliverables.

Strategic Priorities	What will success look like?	By 2023/24 we will have achieved
Improve health and wellbeing through outstanding services	• A positive experience of care for all	✓ Consistent positive real-time feedback from service users, patients, families & carers ✓ 100% of users report co-producing their care plan ✓ Achievement of all access targets
	• Culture of quality improvement, innovation and research	✓ Demonstrably outstanding services ✓ All divisions benefitting from Quality Improvement methodology
	• More people enjoying healthier lives and good mental health	✓ Contribute to reduced population levels of obesity & long term conditions with targeted improvements for our inpatient population and our staff ✓ Reduce death by suicide of service users / patients under our care and improve our support to families and staff post-suicide ✓ Every service recording improved service user / patient outcome measures ✓ Services proactively work with service users and patients to identify and develop the knowledge, skills and confidence people have to manage their own health and care
	• Equal support for our vulnerable and seldom heard communities	✓ Reduced complications from long term conditions and increased life expectancy for vulnerable groups ✓ In partnership with others, achieve top 10% nationally in completing physical health checks for people with serious mental illness and learning disability
Become the best employer	• SHFT is well-led and one of the best places to work in the NHS	✓ NHS staff survey results in top 10% nationally for comparator trusts ✓ Leaders report feeling empowered and supported at all levels
	• A workforce representative of our communities at all levels	✓ Workforce representative of our communities at all levels ✓ In the top 10% nationally for comparator trusts for employing people with lived experience
	• Capability to retain, attract and develop our workforce	✓ Year on year targeted improvement to ensure we are in the top 10% nationally of comparator trusts for recruitment and retention, initially targeting: ✓Staff vacancy level of 5% ✓25% reduced vacancy in Nursing and Medical workforce ✓Reduction in the Trust staff turnover to 12.5%
	• A safe workplace where staff wellbeing is actively supported	✓ Improve staff survey rating for health and well-being to top 10% nationally in staff survey results by 2021/22 ✓ Lowest 10% nationally against comparator trusts for assault, abuse or threat to staff
Transform services through integration and sustainable partnerships	• Seamless local care provided in partnership with primary care	✓ Users consistently report receiving seamless timely access to care with all access targets achieved
	• Care models that are co-designed with users, families and carers	✓ Project evaluation feedback scores high for engagement and delivery of the ambition
	• System integrator and lead partner in the Hampshire & Isle of Wight health and care system	✓ Hampshire & Isle of Wight health and care system delivers the local and NHS Long Term Plan ambitions, for community and mental health services ✓ 360 stakeholder feedback scores highly positive
Improve value	• A sustainable financial plan and realisation of our investment plans	✓ Financial balance, capital investment and service development plans achieved
	• Improved therapeutic care environments	✓ Reported improvement through Patient-Led Assessments of the Care Environment (PLACE) and user feedback
	• Reduced impact on the environment	✓ Achievement of green plan targets & contribution to zero net emissions UK climate change target
	• Improved care by embracing digital technology and innovation	✓ All clinical staff have timely access to records at the point of care ✓ Increased proportion of overall staff time spent on clinical care ✓ Patients and service users who wish to access their records digitally can do so

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 (comprising staff, public and appointed Governors), 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.

Lynne Hunt
CHAIR

Ron Shields
CHIEF EXECUTIVE

Paula Anderson
FINANCE DIRECTOR

Michael Bernard
NON-EXECUTIVE DIRECTOR

Jeni Bremner
NON-EXECUTIVE DIRECTOR

Paul Draycott

DIRECTOR OF WORKFORCE, ORGANISATION DEVELOPMENT AND COMMUNICATIONS

Kate FitzGerald

NON-EXECUTIVE DIRECTOR

Robert Goldsmith

NON-EXECUTIVE DIRECTOR

Dr David Hicks

NON-EXECUTIVE DIRECTOR

Paula Hull

DIRECTOR OF NURSING AND ALLIED HEALTH PROFESSIONALS

David Kelham

NON-EXECUTIVE DIRECTOR

Dr Subashini M

NON-EXECUTIVE DIRECTOR

Dr Karl Marlowe

CHIEF MEDICAL OFFICER

Grant Macdonald

CHIEF OPERATING OFFICER

Heather Mitchell

DIRECTOR OF STRATEGY AND INFRASTRUCTURE TRANSFORMATION

David Monk

NON-EXECUTIVE DIRECTOR

Dr Steve Tomkins

CHIEF MEDICAL OFFICER

Ade Williams

NON-EXECUTIVE DIRECTOR

*Dr Karl Marlowe left the Trust in April 2021 and Dr Steve Tomkins joined the Trust in April 2021

Our clinical services

The Trust is split into five Divisions; four of these are geographically based (Portsmouth and South East Hampshire, South West Hampshire, Mid and North Hampshire and Southampton) with 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 Primary Care Networks. They cover both physical and mental health services and are led by divisional leadership teams headed up by a Clinical Director who continues to work in their own clinical speciality.

Mid and North Hampshire Division

Clinical Director: Dr Victoria Osman-Hicks

Divisional Director of Operations: Nicky MacDonald

Medical Director: Dr Maja Meerten

Director of Nursing and AHPs: Liz Taylor

Parklands Hospital	OPMH functional mental health ward, OPMH organic mental health ward, PICU (Psychiatric Intensive Care Unit), Adult mental health ward, MOD (Ministry of Defence) mental health ward.
Alton Community Hospital	Rehab ward, IV clinic, Tissue Viability clinics, outpatient clinics.
Avalon House	Community hub (Older Persons Mental Health (OPMH), Community Mental Health Teams (CMHT), health clinics, community care)

Portsmouth and South East Hampshire Division

Clinical Director: Dr Riaz Dharamshi

Divisional Director of Operations: Nicky Creighton-Young

Medical Director: Dr Denzell Mitchell (mental health) / Dr Steve Plenderleith (physical health)

Director of Nursing and AHPs: Laura Pemberton

Elmleigh Hospital	Inpatient service for male and females with functional mental illness
Gosport War Memorial Hospital	Two OPMH acute mental health wards, two rehab wards
Fareham Community Hospital	Outpatient clinics, continence service, MSK, occupational therapy
Petersfield Community Hospital	Two rehab wards, rapid assessment unit for older people, Physiotherapy, MIU (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

Southampton Division

Clinical Director: Dr Adam Cox

Divisional Director of Operations: Sarah Olley

Medical Director: Dr Zaid Alabassi

Director of Nursing and AHPs: Richard Webb

Antelope House	Two adult mental health wards, Psychiatric Intensive Care Unit (PICU)
Western Community Hospital	Short stay OPMH organic mental health ward, OPMH functional mental health 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

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

Moorgreen Hospital	Stoneham centre, Southampton Intensive support team
Romsey Hospital	Outpatient clinics, radiology, orthopaedic choice, musculoskeletal (MSK), two rehab wards
Fordingbridge Hospital	Rehab Ward, physiotherapy, orthopaedic choice and occupational therapy
Lymington New Forest Hospital	Stroke rehab ward, Medical Assessment Unit, three rehab wards , frailty, MSK and radiology
Melbury Lodge*	OPMH (Older persons Mental Health) functional mental health ward, acute mental health ward, Mother and Baby unit

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

Specialist Services Division

Clinical Director: Dr Mayura Deshpande

Divisional Director of Operations: Rob Guile

Medical Director: Dr Simon Hill (Adolescent services) / Dr Jennifer Dolman (Adult secure and Learning Disabilities)

Director of Nursing and AHPs: John Stagg

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
Ashford	Low secure unit for adult men with a learning disability
Learning disability services	Community teams, Hospital liaison services and forensic community teams
Children's services	Health visiting, school nursing, Children's Health Information Service, Children in Care, Family nurse partnership

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 operational risk register and our Board Assurance Framework. During 2020/21 we identified and recorded a series of risks specifically in relation to the COVID-19 pandemic that impacted on the Trust; these received detailed scrutiny via the COVID-19 Quality Assurance Committee.

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

- There is a risk that the proliferation of the COVID-19 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

Our Board Assurance Framework identified four strategic risks; aligned to each of the four strategic priorities. During the year, we have sought to more closely align the operational risk areas that underpin each of the strategic risks.

Our strategic risks are:

- There is a risk that we fail to improve health and wellbeing through outstanding services
- There is a risk that we fail to become the best employer
- There is a risk that we fail to transform services through integration and sustainable partnerships
- There is a risk that we fail to improve value

More information on our risks and how we manage them can be found in the Annual Governance Statement, from page 107 and further detail on delivery of our strategic priorities is set out in the Performance Report on pages 28 to 34.

Going concern disclosure

After making enquiries, the Directors have a reasonable expectation that the services provided by the Trust are expected to continue to be delivered by the public sector for the foreseeable future. For this reason they continue to adopt the "going concern" basis in preparing the Accounts.

Our response to COVID-19 and the impact on our services

2020/21 has seen our staff and services respond to the effects of the COVID-19 global pandemic. Our staff and services have fundamentally transformed the way we work. We saw a phenomenal effort by our teams to work differently and collaborate with partners across the health and care system. The focus has been to provide the safest, most effective care possible during the pandemic, for those with COVID-19 as well as those with other health needs.

Some examples to illustrate these efforts include:

- We recruited an additional 580 staff (about 10% of our workforce) including students and 278 substantive recruits.
- Around 400 colleagues were redeployed into different settings - this includes trainers redeploying into clinical practice, staff transferring to acute hospitals, and corporate support staff moving to help with the distribution of supplies to our hospitals.
- We made a significant number of additional beds available at our community hospitals. These plans mean we are able to quickly react to any future increase in cases. We also supported acute hospitals to ensure there were beds available for people on discharge.
- We facilitated a major shift towards supporting patients using video and telephone, where this was clinically appropriate. This enabled us to minimise the risk of infection whilst continuing to provide vital care. We have seen a monthly increment in the use of video appointments over the year – with over 8,000 appointments delivered in March 2021 compared with 30 video appointments delivered in March 2020. The Lighthouse, a safe haven for people with a mental health crisis in Southampton, used text messaging and telephone to support patients, with over 600 contacts.
- We implemented a risk assessment tool to help keep our staff safe. It accounts for major risk factors including age, gender, ethnicity and underlying health conditions. As at 31 March 2021 94% of staff at risk have completed the risk assessment, including over 99% of all staff from Black, Asian, and minority ethnic heritage, as well as 97% of staff aged over 50.
- The Trust developed an online wellbeing hub for staff enduring the stresses of working in the pandemic. During 2020/21 more than 3,300 staff have accessed the site for resources, guidance and links to additional support. We also set up a dedicated ‘Listening Ear’ coaching service which has been used by over 100 staff with overwhelmingly positive feedback.
- As the largest provider of mental health services in the county, we also developed a psychological support offer to partner organisations, this included access to our wellbeing hub and fast track access to psychological therapies.
- Efforts have been made to address the backlog of childhood immunisations through specific catch-up initiatives and additional capacity. The flu vaccination programme was provided for children from year R to year 7, plus children in all year groups that attend a Special School. The children were vaccinated between Sept 2020 - January 2021, achieving an uptake of over 75% . Many community clinics were provided throughout this period of time, for those children that missed the school session. For secondary school pupils, many sessions were carried out on the school sites when the schools were closed/had limited numbers attending and where this was not possible, community venues were used and parents invited to bring their child.
- Enhanced support for care homes, and a programme of structured medication reviews.
- Our patient experience team established virtual support groups for carers, many of whom were struggling with the effects of lockdown.
- The Trust led an international research effort into the psychological effects of COVID-19. The findings of this research helped to inform the World Health Organisation strategy, and is informing the way we respond to the mental health implications of the pandemic on our society.

We have worked with our system partners to vaccinate our staff, with 90% of our eligible staff having received their first dose as at 31 March 2021. We also redeployed a large number of staff to the system-wide COVID-19 vaccination programme, as well as supporting acute trust colleagues with additional staff for their critical care teams. We are also pleased to report a definite downward trend in the numbers of patients in our hospitals with COVID-19 as at the end of March 2021.

Defining the 'new normal'

As the situation continues to ease, we will be reviewing our visiting hours guidance and working to return our services to 'business as usual' wherever possible, whilst also ensuring we learn from lockdown and embrace those additional ways of working - such as video appointments and telephone assessments - which have been well received by our patients and staff.

New Long-COVID Service

We are part of a new service now available in Hampshire to support 'post-COVID' or 'long-COVID' patients and COVID-19 positive patients in the community. Six clinics now operate across Hampshire and the Isle of Wight.

Thank you

We would like to take this opportunity to thank all of our staff and volunteers for their phenomenal efforts during this time. Their work has been truly remarkable and their dedication to providing care and support, inspiring. As a small token of thanks and appreciation, we granted all staff an additional day's annual leave to take in 2021/22.

OUR YEAR 2020/21

In addition to the Trust's response to the COVID-19 pandemic described above, the section below highlights some of the other key moments of our year.

April – June 2020

- In May our School Nursing service launched a new text messaging service – ChatHealth. The service is a quick and easy way for parents with school aged children to get help, advice and support about their child's physical, mental and emotional wellbeing.
- In June, our Director of Workforce, OD and Communications shared an impactful and though-provoking reflection of inequalities facing Black, Asian and Minority Ethnic (BAME) colleagues within the NHS, and described the action we are taking to improve equality, diversity and inclusion in our workforce and our local communities.
- Early on in the pandemic, we introduced weekly Zoom meetings for carers across Hampshire to combat feelings of anxiety and loneliness and to allow carers of all backgrounds to share, support and talk to each other.

July – September 2020

- In July 2020 we received encouraging results of an audit of our approach to patient engagement. The audit authors were positive about what they described as "significant levels of service user engagement". The audit was carried out by an external organisation, and considered our approach compared to the best-practice national NHS framework for patient engagement.
- August saw us launch a new School-Age Immunisation Service with a team of 40 specialist nurses, healthcare support workers and support staff providing childhood vaccinations across Hampshire.

- At the beginning of September we opened Ashford, a new low secure Learning Disability Residential Unit in Calmore. Ashford is a purpose built 10 bedded ward specifically for adult men with a learning disability who have been detained under the Mental Health Act. The new unit represents an investment of around £10 million in learning disability services and was welcomed by the 40+ strong multi-disciplinary team who work there – comprising nurses, support workers, occupational therapists, speech and language therapists, social workers, psychologists and psychiatrists.
- At the end of September we were pleased to welcome local Basingstoke MP Maria Miller to open the new therapeutic garden for patients at Parklands Hospital in Basingstoke. The garden was developed with support from our charity, Brighterway.

October – December 2020

- Our Community Perinatal Team were awarded full accreditation status for a second time, meeting the high standards set by the Royal College of Psychiatrists Quality Network, which requires three-yearly re-assessment. The award highlights the quality of perinatal care at the Trust, which has been featured in award winning documentaries including Louis Theroux.

- In October we gave patients the opportunity to create their own photography and poetry, which was exhibited throughout Hampshire. Their creative work is a result of Depth of Me, a project delivered by Southern Health in partnership with Hampshire Cultural Trust. The project's aim was to provide a platform for patients and carers to create their own photography and poetry to reflect their story.
- Also in October, we marked 10 years since the first patient started their treatment at italk, our psychological therapy service provided in partnership with Solent Mind. Since then, italk has supported over 90,000 patients to recover from a common mental health condition, the equivalent to one in every 15 people in Hampshire.
- In November we were delighted to announce that two of our teams had been shortlisted at the 2020 HSJ Awards, recognising their outstanding contribution to healthcare. The Frailty Admission Avoidance Team have been shortlisted in the 'Primary Care, GP or Community Initiative of the Year' category and the Trust's Media and Communications Team was a finalist in the 'Communications Initiative of the Year' category, for a suicide prevention campaign which reached over one million people.
- November also saw our learning disability team celebrate after two of its service user-led initiatives struck gold at the National Service User Awards. A young service user called Jordan (supported by the Trust's North Hampshire Community Learning Disability Team), was recognised for his work talking to and educating paramedics, GPs and other healthcare professionals about living with learning disabilities, tailoring health care services and how to improve hospital appointments for people who may struggle with them. The other shortlisted entry was for Southern Health's Experts by Experience Easy Read Group, which was set up by people with a learning disability to translate a multitude of healthcare information into more easy-to-understand formats for those with a learning disability.
- Throughout November we celebrated our staff in our annual staff recognition awards. This year was slightly different and the awards were presented by our Executive team directly to the winners in order to comply with COVID-19 restrictions. The presentations were filmed and shown to all staff. The runners up received a goody bag, full of fantastic treats.

January – March 2021

- Tracey Edwards got the New Year off to a good start after being awarded Security Manager of the Year in the 2020 Security & Fire Excellence Awards, in recognition of her pioneering approach to improving care outcomes for children and young people with complex mental health needs. As well as noting Tracey's strategic use of video surveillance, the award also recognises her voluntary contributions to the wider field of mental healthcare security, and her efforts to improve understanding of mental healthcare issues with various police forces.
- The Trust is working towards full accreditation in the Triangle of Care, which is a set of principles established by the Carers Trust to ensure joined up work and support between patients, carers and staff. In January 2021, we submitted our application to receive the first 'star' of accreditation, following significant efforts to embed these principles in our services.
- In January we teamed up with Solent NHS Trust and Isle of Wight NHS Foundation Trust to open a number of clinics across Hampshire and Isle of Wight to help patients suffering from the effects of Long- COVID. The new service is part of a £10m initiative by NHS England who are funding 69 clinics across the country.
- Also in January, we launched a new centre of treatment to support patients with mental health illness. The Neuromodulation Centre includes existing services and a new Repetitive Transcranial Magnetic Stimulation Therapy service (rTMS), offering a different treatment to patients with depression, with quick recovery and no need for anaesthetic.
- In February we announced our plans for Southampton and Basingstoke to develop two new mental health wards, totalling 28 beds, dedicated to supporting some of the most vulnerable women in Hampshire. The £3.3m investment will see a 10-bed psychiatric intensive care ward open in Antelope House, Southampton and an 18-bed acute mental health ward at Parklands Hospital, Basingstoke. Both wards will provide much-needed mental health provision to women in crisis, preventing the need for treatment to be provided further afield. Patients have been closely involved in helping to design and name the new wards.

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 of 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 37,114 (patients, staff and general public) participated in National Institute for Health Research (NIHR) portfolio research projects. We also work closely with our key stakeholders namely, the 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.

1.3 PERFORMANCE ANALYSIS

We are performing well against our regulatory and contractual targets for the people who use our services. Performance dropped due to the cessation of services because of the COVID-19 pandemic. This included elective outpatients, diagnostics and health visiting where staff were redeployed to support inpatient and community services.

Below is a summary of our targets for our mental and physical health services which are reported regularly throughout the year to the Board:

Mental health:

Metric	Description	Priority for	Required target to achieve minimum compliance	2020/21 Whole Year 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%	99.7%	Yes
Mental Health 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%	4.9%	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%	98.1%	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%	93.7%	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%	88.7%	Yes
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%	99.2%	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%	98.3% (March 2021) *The Trust met this target consistently throughout 2020/21*	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%	99.7% (March 2021) *The Trust met this target consistently throughout 2020/21*	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%	61.2% (March 2021) *The Trust has consistently met this target since July 2020*	Yes
Mental Health risk assessments completed and reviewed	All mental health patients have effective and timely risk assessments.	Trust (Mental Health)	Greater than or equal to 95%	85.1% (March 2021) *The Trust did not meet this monthly target in 2020/21*	No See note on page 26

Physical health:

Target	Description	Priority for	Required target to achieve minimum compliance	2020/21 Whole Year Performance	Achieving Target (Yes/ No)
Referral to Treatment	% of patients on an incomplete treatment pathway with a waiting time of less than 18 weeks.	NHS Improvement	Greater than or equal to 92%	88.6%	No See note below
Diagnostics	% Within 6 weeks	NHS Improvement	Greater than or equal to 99%	85.9%	No See note on page 27
Minor Injuries	% within 4 hours	NHS Improvement	Greater than or equal to 95%	99.8%	Yes
End of life – dying in preferred location of care	% patients dying in preferred place of care	NHS Improvement	Greater than or equal to 80%	92.9%	Yes
Rapid response performance	% visits completed within 2 hour target	Commissioner	Greater than or equal to 80%	94.2%	Yes
Community information data set compliance	% data elements	NHS Improvement	Greater than or equal to 50%	DQMI* 82.1%	Yes

*Data Quality Maturity Index

Mental Health Risk Assessments

The proportion of patients with a risk assessment completed in March was 93.4%; the Trust did not meet the target for risk assessments being both reviewed and completed on a monthly basis in 2020/21. The Trust has continued to make improvements in ensuring risk assessments are complete and recorded in the correct part of the patient's record for good risk management. Developments in our electronic patient record will support further improvements and the focus of audits will be on the quality of the assessment.

Referral to treatment

In line with the national directive to prioritise delivery of operational services, the Trust stopped elective outpatients for all but urgent cases during the COVID-19 pandemic; leading to underperformance against the national target for 18 weeks referral to treatment. Referrals from GPs dropped significantly during the first quarter of the year and then increased as lockdown was eased and restoration and recovery plans were put in place. Services were required to change the way they worked to ensure social distancing, the

use of PPE etc. and where appropriate services have been provided virtually through phone and video calls.

Diagnostics

Compliance against this standard reduced as a result of response to the COVID-19 pandemic where all but urgent diagnostics were paused during each lockdown. As each lockdown eased restoration and recovery plans were enacted to manage waiting lists and new referrals safely and effectively. The Trust did not meet the national standard in February and March 2021 because of the failure of a DEXA scanner. A new scanner will be operational in 2021.

How we monitor performance

Further information on how we monitor performance can be found on page 112 in the Annual Governance statement.

Improvements in Data Quality

We have continued to build on our data quality work through the utilisation of the NHS Data Quality Assurance Framework. The framework focuses on enabling organisations' capability to excel in data quality practice, reviewing technology, skills and education. This is also underpinned by key aspects of leadership and communication. A current state analysis has been completed for each of the themes and we have oversight of the resulting actions through the Trust Information Governance Group.

Data Models and Information Standards notices are reviewed by our Information and Development teams as they are advised. We currently submit the following national datasets:

- CDS – Commissioning Dataset – Inpatient and Outpatient activity
- MHSDS – Mental Health Services Dataset
- CSDS – Community Services Dataset
- ECDS – Emergency Care Dataset
- IAPTUS - Improving Access to Psychological Therapies Dataset

Regular reviews are completed of our national datasets in order to ensure that our principal Electronic Patient Records (Servelec Rio) is configured and operating procedures reflect recording practices that allow us to submit robust information.

External benchmarking is currently included within our reports where this has been investigated and is available. This includes patient experience and Integrated Performance Review metrics including regulatory and commissioner standards. Whilst this relates to performance in the first instance it can assist in highlighting data quality issues that may contribute to us being an outlier. The Data Quality Maturity Index (DQMI) is a national quality indicator of the Trust's data quality. This is regularly analysed and informs discussions on areas for improvement and the ongoing development of our datasets.

The Trust data quality audit process is in place to review two indicators monthly through the audit of patient records. This checks entries against the standards for good data quality including accuracy, validity, completeness and evidence that NICE guidance is followed where applicable.

During 2020/21 data quality audits were suspended as clinical and corporate staff were redeployed to support the Trust and local system response to the COVID-19 pandemic. Audits resumed in April 2021.

Summary of our performance

In the following pages you will find a summary of our performance over the last 12 months in relation to our strategic priorities.

Improve health and wellbeing through outstanding services	
What will success look like:	**Update for 2020/21**
A positive experience of care by all	• Please see page 56 for an update on our patient experience commitment • Please see page 67 for our section on carers • We have now established truly co-produced feedback and audit systems including Service User Led Standards Audits (SULSA) of Section 136 place of safety*, out of area beds, physical health matters and a newly co-produced carer's survey. All of these are currently undertaken on a quarterly basis to enable effective monitoring and to ensure actions are taken to continually improve the quality and delivery of our services and support to carers. Findings are shared with the services to ensure areas for improvement are identified and enacted. Weekly community meetings are held with all inpatient services, to enable us to receive real-time feedback to enable issues to be dealt with promptly. • We have implemented a new complaints process to reduce the time taken to respond to complaints and deal with concerns more proactively. Our average time for responding to complaints has reduced from 57 working days in March 2020 to 11 working days in March 2021.
Culture of quality improvement, innovation and research	• We have reduced the number of Trust policies by 25% and simplified those we have kept to reduce their size and complexity to make it easier for staff to understand and utilise. • We have developed a safety commitment through engagement with service users and staff. • Patient Safety Practitioners are in place in every clinical division. We are now recruiting to a Patient Safety Partner role who are service users to support us to make safety improvements. • We have set up an OPMH in-reach service into care homes to reduce A&E attendances and admission to hospital as well as to provide support for discharges from hospital. Training is also provided to care home staff with staff and families stating they feel reassured and supported to have access to mental health expertise. • We have run a pilot to develop enhanced community crisis service response models to deliver rapid assessment and intensive support for those living with dementia and their carers to reduce the need for hospital admission. • Following the temporary closure of Poppy ward for refurbishment, staff were redeployed to set up an Intensive Support Team, between December 2020 and March 2021. 46 out of 54 patients who were supported by the service were cared for at home and did not require a hospital admission, with very positive feedback from carers and families.
More people enjoying healthier lives and good mental health.	• We are working within the HIOW (Hampshire and Isle of Wight) ICS (Integrated Care System) to develop a population health management approach to help identify and address local population health needs, and in 2020/21 the contract for developing the data analytics system was identified and forerunner sites agreed. The Willow Group (Group of GP practices in South East Hampshire) is one of the pilot areas.

	• Our IAPT (Improving Access to Psychological Therapies) recovery rates remain above the national average with more people reporting that their anxiety or depression has improved following treatment during 2020. • Following a transformation focus, the West Hampshire Community Diabetes team are supporting GP's management of patients with type 1 and type 2 diabetes through clinics, education and help from diabetes co-ordinators. As a result there has been consistent improvement in achieving treatment targets and the performance is now above the England average for type 1 diabetes. During the pandemic the team have completely transformed the Diabetes Service to a virtual platform, running clinics and education courses. • In South East Hampshire the team have been successful in bidding for NHSE Transformation monies to evolve the SENSE (a discreet blood glucose monitor) project in working with PCNs, expand the patient education portfolio and develop a remission strategy. Virtual DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) started on 8 March 2021 and the team continue to receive positive feedback from GPs, practice nurses and people with diabetes.
Equal support for our vulnerable and seldom heard communities	• We produced a suicide prevention awareness campaign which was nominated for a Health Service Journal (HSJ) award. • An additional member of staff has been recruited to support bereavement in the Trust as well as working across the Integrated Care System. • Work is being undertaken to support the emerging evidence on the long term impact of COVID- 19 on population health, unemployment, social isolation, substance misuse, safeguarding and anxiety related disorders. • Evidence has previously shown that female nurses have approximately a 23% higher risk of suicide than women in other occupations; this is potentially exacerbated by the pandemic. A support hub for staff has been set up • We have recently been accepted as an 'Early adopter' site to support the delivery of the National Reasonable Adjustment Flag Project, and to ensure equal access to services by people with an impairment across the National Health Service. • We have established 'The Expert by Experience Easy Read Group' who produce information across the Trust to support service users to access and engage with services.

*A Section 136 place of safety is normally residential accommodation provided health services where a person can receive mental health care and support. A Section 136 is normally given to someone who appears to be experiencing a mental health crisis in a public place and can be picked up by the police and taken to a place of safety to receive help.

Become the best employer	
What will success look like:	**Update for 2020/21**
Southern Health is Well-led and one of the best places to work in the NHS	• Our Staff Friends and Family Test results show our staff that would recommend Southern Health as a place to work is up 5.5% on last year (in 2019 – 61% and in 2020 – 66%). Results are also up by 5% for staff recommending the Trust as a place to receive care (in 2019 – 69% and in 2020 – 74%). • Our cultural insights staff survey shows that staff feel enthusiastic and optimistic about working in the Trust.

A workforce representative of our communities at all levels	• Please see pages 35, 36, 37, 76, 89 and 90 for details of our inclusion work this year.
Capability to retain, attract and develop our workforce	• An additional 470 staff have been employed in the Trust in the last two years including 98.85 FTE (full time equivalent) nurses, 50.4 FTE doctors and 125.94 FTE health care support workers. • Staff turnover (excluding fixed term contracts) has reduced by 25% over the past two years from 16.2% in April 2019 to 12.1% in March 2021. • Inpatient mental health nurse staffing remains a challenge. In the annual mental health benchmarking data published in November 2020, the Trust compared favourably to comparators with the Trust ranking in the lowest percentile for vacancies across the 53 organisations benchmarked. • We have developed a number of recruitment campaigns using videos, social media, vlogs with new types of roles including rotational posts. • 30 additional nurses and four specialty doctors have been brought in through International recruitment. • We have adapted our recruitment model in response to COVID-19 and have further reduced the time from advert to start date from 12.08 weeks (March 2020) to 10.28 weeks (March 2021). These recent changes have complemented a QI programme of work that began in August 2018 when the monthly average was 14.78 weeks.
A safe workspace where staff wellbeing is actively supported	• We have seen a positive change in staff reporting errors and incidents and feeling safer at work (3.6% better than national average from the national staff survey) • Less of us are experiencing physical violence at work (3.8% better than national average from the national staff survey) • Staff feel that the Trust deals with incidents fairly and learns from them to ensure they do not happen again (3% better than national average from the national staff survey) • We established a staff wellbeing hub to provide support for staff to feel fit and healthy at work including access to MSK services, psychological support, advice and guidance. The Trust is also leading the establishment of a wellbeing hub for Hampshire and Isle of Wight (HIOW) in partnership with Solent NHS Trust.

Transform services through integration and sustainable partnerships	
What will success look like:	**Update for 2020/21**
Seamless local care provided in partnership with primary care	**One Team** The One Team model provides a co-ordinated approach between primary care, community services and social care. It provides timely, comprehensive, holistic, person centred assessment, care planning and case management. As an example, in the South West our frailty teams are also part of the provision and accept patients onto their caseload, directly after a clinical conversation. **Enhanced health in care homes** This is now established in all PCNs (Primary Care Networks). MDTs (Multi-disciplinary teams), virtual ward rounds in care homes and strengthened relationships have enabled a more proactive approach to patient management as well as training for the staff in homes. As an example, in the South East there is a dedicated team within the PCNs who carry out weekly virtual ward rounds pro-actively. The Care home team also provide education around safeguarding, falls and managing medication to help mental health illness.

	PCN development
	• We have models in place to enhance the psychological support and medical care available within PCNs. Some examples include:
	  o In the South East we worked with the PCNS to establish a COVID-19 vaccination centre and deliver housebound vaccinations.
	  o We have recruited Health and Wellbeing coaches and a social prescriber (Someone that can refer people to a range of local, non-clinical services to support their health and well-being).
	In Southampton a Partnership Board has been established with the PCN and an operating model has been developed with a number of Mental Health Practitioners appointed.

Care that is co-designed with users, families and carers	**Willow ward closure and new model of care** • Willow Ward (ward for Learning Disability patients), closed in September. The Learning Disability Transformation Board is developing a new service model to ensure people with Learning Disabilities who experience a crisis are supported in the community. **Specialist Community Forensic Team (SCFT)** • The SCFT was commissioned by NHSE (NHS England) and commenced in November 2019. The funding has been agreed with the Provider Collaborative for another year. The team have partnered with a number of local colleges to offer adult education. They have also partnered with Mayfield Nurseries who offer a range of wellbeing group opportunities. The team also has two peer support workers. **Integrated Intermediate Care model and urgent care response** • We have worked in partnership with Hampshire County Council to develop and deliver an integrated workforce to support patients to remain in their own homes and receive appropriate rehabilitation and support in the community. • In the Mid and North we have developed Neighbourhood Therapy Teams which provide therapies into individuals homes as first line treatment where appropriate. • In South East Hampshire delayed transfers of care are at the lowest level since records began through rapid mobilisation of 'Discharge to Assess Pathways'. **IAPT (Improving Access to Psychological Therapies) for long term conditions** • We have developed a number of programmes to support people with long term conditions including Building Resilience, Living Well and Coping with Long-COVID which have been positively received by service users. We are working closely with community teams, acute trusts and PCNs, providing training to staff, patient consultations and taking part in MDT meetings. **Community Mental Health Framework** • We have been an active part of the ICS (Integrated Care System) board in planning and developing service models that deliver the Community Mental Health Framework. We have identified areas of deprivation and higher need and worked with PCNs to develop models for increased secondary mental health support in Primary Care. **Older Persons Mental Health** • In South East Hampshire we piloted a successful intensive support service (IST) which has reduced admissions and has been well received by patients and families. We have also started virtual carers groups. • In Southampton we have appointed peer support workers for both our Community Mental Health Teams and Lighthouse service. We are working closely with Citizens Advice, Solent Mind, employment support and homeless services to provide holistic support to enable recovery.

	Crisis Care • We have developed a Communication and Engagement strategy to ensure service user engagement, as well as the involvement of all key stakeholders. • We are currently building an additional 18 female bedded ward in Parklands Hospital which will provide timely access, close to home and an improved therapeutic environment. Over 100 patients with specialist mental health needs have been helping to design the layout of the new ward, the look and feel of the therapeutic corner, the patient lounge and staff areas. • Due to the success of the Lighthouse service, we've now had the funding approved for the second Lighthouse in the East of Southampton.
System integrator and lead partner in the Hampshire & Isle of Wight health and care system	**Restoration and Recovery** • We have worked in partnership with other providers and commissioners to deliver an effective COVID-19 response during the year and to recover and restore services quickly and effectively once it has been safe to do so. We have delivered responsive and flexible solutions together, reducing unnecessary bureaucracy and delays and developing creative solutions to improve access, experience and outcomes. • We have worked with University Hospitals Southampton (UHS) and Solent NHS Trust to harmonise systems, optimise collective resources and deliver seamless high quality care by designing and delivering integrated models of care and engaging with wider system partners as required. **Provider Collaborative** • We have been working with the Adult Eating Disorders Provider Collaborative to provide treatment closer to home, reduce inpatient lengths of stay and establish a clinically-led partnership of local providers who work together with service users, carers, local commissioners and the wider system. • We are hosting the HIOW service for Maternal Mental Health in partnership with maternity services to integrate and embed the Maternity Psychology pilot. It will become a multidisciplinary service, offering seamless and timely intervention to women and their families experiencing mental health difficulties directly arising from, or related to, the maternity experience. The pilot has focussed on the development of a birth trauma pathway, development and delivery of an antenatal anxiety group and supervision of the Perinatal Mental Health midwives. There is a stepped mobilisation from the pilot to the new service which will form part of commissioned provision from April 2022 to meet NHS Long Term plan ambitions. **Partnership Working** **Southampton IAPT:** we have implemented an additional intervention service to support service users who have more intensive requirements than standard IAPT services, to reduce the need for secondary care mental health services. This is in partnership with Dorset Healthcare. **Long-COVID Clinics:** developed in partnership with Solent NHS Trust, our acute hospital partners and local GPS. The service provides therapeutic interventions across HIOW managed by consultant-led MDT and including italk, video consultation, and use of a *Livingwithcovid* App to support assessment and rehabilitation.

Improve value	
What will success look like?	**Update for 2020/21**
A sustainable financial plan and realisation of our investment plans	Please see the full financial performance update on page 34.

Improved therapeutic care environments	• We have designed and built a new learning disability unit. The new purpose built Ashford Unit 10 bed Learning Disability Residential Unit opened in September 2020
	• We have re-provided and expanded the CAMHs low secure services unit. Austen House was opened in September 2019 and provides a nationally recognised and respected environment for treatment and rehabilitation.
	• We have supported staff in the provision of specialist environments with reduced ligatures for acute mental health care. We have reduced the risk of fixed point ligatures by installing door top sensors across our mental health units to bedroom doors, shared bathrooms and ward toilets.
	• A new Nurse Call and Staff Attack System has been installed at Leigh House and a new enhanced sensory room and seclusion suite have been completed.
	• At Ravenswood and Southfield disabled bathrooms have been upgraded and adapted.
	• A CT scanner has been replaced at Lymington Hospital
	• We have used a priority system to address our ongoing annual maintenance programme ensuring services benefit from fit for purpose environments and that we meet regulatory requirements.
	• Roofs are being replaced at Alton Community Hospital and the Bridge Centre.
	• We have also secured national funding to deliver:
	  ○ An 18 bed new ward at Parklands Hospital
	  ○ Upgrade to the Section136 suite (see glossary for definition) in Parklands Hawthorn1 ward to provide better provision for nutrition and shower facilities
	  ○ Eradication of dormitories in Gosport War Memorial Hospital across two wards

Reduced impact on the environment	• Please see Appendix 1 for our full sustainability report. • We are working in partnership with local charities to reduce our waste cost and to support the recycling and repurposing of Trust depreciated assets. • We have appointed an Energy and Sustainability Manager • We have reduced our gas and electricity consumption. • We have installed a Combined Heating Plant (CHP) to create electricity from hot water required for clinical services; this aims to reduce carbon and costs at Petersfield and Parklands Hospitals.
Improved care by embracing digital technology and innovation	• We have continued to roll out video appointment solutions and the uptake of this innovation has enabled our workforce to continue to provide quality care and business as usual functions during the pandemic. • Remote working solutions have contributed towards the estate's rationalisation and sustainability initiatives within the Trust, helping to meet the targets set. • The rollout of RiO Mobile, a mobile based version of the Electronic Patient Record, has allowed rapid record taking to be undertaken, particularly during the initial stages of the pandemic, saving around 50% of the time to complete a record versus the standard laptop /desktop instance of RiO. This initiative has been subsequently rolled out to our physical health and children's services, with over 500 additional devices being issued to clinicians.

	• The addition of iPads to wards to allow patients to contact family members has been highly successful, in times when visits have been restricted. This addition has provided a crucial lifeline to patients wishing to contact family members. • Security of our systems and networks is the bedrock of a safe, secure environment protecting both our clinicians and patients. The completion of the rollout of Windows 10, our continued Cyber Essentials Plus accreditation and compliance with the national Data Protection and Security Toolkit ensures that staff both know how to operate systems safely and are operating them in the safest, most secure manner possible.

Financial Performance

When the scale of national response that was required to respond to the pandemic became clear in March 2020, alternative financial arrangements were put in place for the 2020/21 financial year. The overall approach was to reduce burden, increase cash flexibility and give confidence about the short term financial position to NHS Providers, 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 funding arrangement as well as the commitment that legitimate additional costs incurred as a result of responding to COVID-19 would be funded.

This effectively removed all local contracts with CCGs (Clinical Commissioning Groups) and NHS England and funded all organisations to a breakeven position for the first six months of the year. For the second six months of the year funding allocations were made to Integrated Care Systems (ICS) to manage and these were allocated to organisations within the local ICS.

Within this context, using the NHS England / Improvement adjusted financial position (previously described as the control total) we achieved a small surplus of £133k so effectively a breakeven position. The total income for the year was £383.3m (19/20 £337.3m) which included funding for COVID-19 related costs of £16.5m, the income and expenditure of the centrally procured and pushed out PPE provision of £3.3m and a payment to recognise the amount of annual leave being carried forward by staff (and therefore likely to cause cost) of £4.2m. Additional Investments were agreed during the year to support hospital discharges as well as the long term plan for mental health. We are working with Commissioners to secure these into our financial baseline over the coming months as we work towards contract arrangements being reinstated in the second half of the financial year 2021/22.

Although during the year there were no new national efficiency requirements set, as a Trust with unmet carried forward cost improvement requirements we did continue to work with teams to identify and implement cost savings where possible. During the year the Trust delivered savings of £18m (4.7% of the cost base) of which £9.9m were achieved recurrently. The initiatives comprised a number of workforce redesign schemes, procurement opportunities and reduction of corporate overheads.

A further important aspect of the cost reduction achieved in 2020/21 was a reduction in the use of out of area placements for mental health patients. In the previous year we had seen spend as high as £14.4m and in 2020/21 this reduced to £6.7m. The vast majority of this expenditure was within two contracts we had established with private sector providers where we successfully put in continuity of care arrangements which support quality of care and patient experience. During 2021/22 we are undertaking capital projects to develop a further acute ward and female PICU ward within the Trust to reduce our reliance on the private sector.

Clearly 2020/21 was a slightly more challenging year in terms of the use of temporary staffing with agency spend increasing. An element of this linked to additional and adapted services as part of our COVID-19 response but there also continued to be pressures around medical staffing. In 2020/21 our agency costs increased to 6.4% of the total pay bill (5.7% in 2019/20) and for medical pay costs the total use of agency locums was 24% (21% in 2019/20). Although this may look like a deteriorating position it is not as our overall medical vacancies have reduced over that time. We have deliberately used more locums to ensure that our clinical services are appropriately supported.

Finally to give some detail on expenditure linked to COVID-19, the Trust spent £16.8m, £300k more than the allocation, on responding to the impact of the pandemic with £9.8m on additional staffing costs; be that from existing staff working overtime and additional shifts; retirees and student nurses brought back to, or deployed early within the Trust on fixed term contracts to support clinical services; or through additional hours commissioned through staff bank and agency arrangements. The remaining £7m comprised new ways of working to facilitate remote management of patients through online appointments & included virtual appointment software solutions; food and beverages provided to staff; decontamination of clinical areas including increased cleaning, additional laundry costs, and minor works in buildings to replace equipment which couldn't be easily wiped down, and to create COVID-19 safe environments which included the segregation of patient pathways; additional beds and associated equipment within the Trust's various inpatient units to increase inpatient care capacity; PPE (Personal Protective Equipment) including security and its distribution (in addition to the PPE that was provided under Department of Health contract arrangements and funded centrally); increased provision of staff uniforms in services that previously didn't wear them; payments to third party cleaning contractors to allow them to pay full sick pay to shielding staff and other areas including enhanced COVID-19 safe patient and staff transport and communications on service delivery which was changing during the pandemic.

The above paragraphs focus on the Trust's position against the NHS England / Improvement (NHSE/I) adjusted financial target. 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 at the right value.

The Trust is reporting income of £383.3m and operating costs of £380.7m resulting in an operating profit of £2.5m compared to £2.3m in 2019/20. Once non-operating costs (financing costs) have been considered the position is a deficit of £2.6m. The difference between this and the adjusted financial positon for NHSE/I of £0.1m surplus relates to the accounting of impairment costs and depreciation on donated assets.

The cash balance increased from £13.3m to £46.8m at 31 March 2021. This increase was principally as a result of the cash backed annual leave accrual, higher capital creditors and the receipt of income relating to 2021/22.

The Trust invested £14.6m (including donated / grant funded assets of £0.3m) in a range of capital projects in 2020/21. This included £2.2m for the final year of the major secure services development comprising a new learning disabilities residential unit which was completed late summer of 2020 and a low-secure adolescent unit (Austen House) which was opened in 2019; £4m (of the £9.5m programme) for the eradication of mental health dormitories which has attracted national funding; and £0.9m for the replacement of the MRI scanner at Lymington Hospital with installation by July 2021. The remainder of the general capital programme of £8.1m covered projects for reducing ligature risks, improving health and safety, planned maintenance, new medical devices and investment in digital / information technology.

Financial Outlook

The planning process for 2021/22 was suspended due to the second wave of the virus, and therefore the initial arrangements for the year are broadly a continuation of last year's nationally calculated block and top up funding, but for the first six months (April to September) only. For this period the NHS organisations across Hampshire have worked together to develop a financially balanced compliant plan for the system which includes a planned breakeven for our Trust. Further guidance is expected for the remainder of the year but it is not expected to be radically different and if it results in a deficit position we would expect this to be supported by a Financial Recovery Fund to breakeven, as per the pre-COVID arrangements.

Public Sector Equality Duty

The Trust is committed to promoting diversity and inclusion (D&I). We aim to ensure that respect for equality, diversity and human rights are embedded in all areas of our service delivery, patient care, planning and employment. We ensure the services we deliver are accessible, responsive and appropriate for the diverse community that we serve. We treat patients, visitors and staff with dignity and respect. The Trust embraces this commitment and champion's equality, diversity and inclusion to truly empower people and put them at the centre of everything we do, so they feel safe to raise concerns, make changes happen and recommend Southern Health as a place to work and to have care and treatment. The Trust's Diversity and Inclusion plan aims to provide a culture of inclusion, where everyone is valued for the individual skills, talents, background and knowledge that they bring to their team and service is essential. A more inclusive and diverse workforce will lead to improved patient experience, improved retention and staff engagement.

We understand that equality, diversity and inclusion are important in achieving our vision and integrating our organisational values in everything we do.

The Public Sector Equality Duty consists of a general duty and specific duties. The general duty requires public authorities to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not.

We have over 400 Allies (an inclusion Ally is a colleague who supports all colleagues, and speaks up against complacency and injustice) at Southern Health that provide a platform to the seldom heard groups and help advance equal opportunity.

In response to the Public Sector Equality Duty specific duty, the Trust publishes the Workforce Diversity Scorecard annually on 31 January which provides a breakdown of the demographic of our workforce, recruitment and selection, employment banding, employee relations and recruitment and selection.

The Gender Pay Gap has decreased from 20% to 2019 to 19% in 2020 and we will continue to engage our workforce to co design improvement priorities to continually reduce gender inequality.

Our latest Workforce Race Equality Scheme report shows that 9.7% of our workforce are from BAME backgrounds and representative at Bands 2, 3, 5, 6 and 9.

We will continue to measure our progress against yearly analysis of Workforce Race Equality Standard, Workforce Disability Equality Standard and Equality Delivery Standard 3 metrics, staff survey and Stonewall Workplace Equality Index.

Promoting equality of service delivery

Since March 2020, DA Languages provide the Trust with a translation and accessible version service. This sole contract with one provider enables us to have on demand access to telephone, video and face to face interpreting for patients, service users and staff.

Due to the Pandemic, interactions with community groups have been restricted, with many local groups closing their doors over lockdown and only recently beginning to open. With evidence coming to light of the effects of COVID-19 on BAME groups (Black, Asian and Minority Ethnic people), this has seen community centres being closed for longer in an effort to prevent transmission within high risk groups. We have continued to link in with Romsey Disability Network and Hampshire Hate Crime Network virtually through online meetings. Southampton City Council have a community response team that we regularly link in with, particularly due to the pandemic and vaccination uptake. We have also had coverage on a local ethnic radio station and advertisement of vacancies in national papers and on the Stonewall website.

Further information can be found on pages 76, 89 and 90.

Social, community, anti-bribery and human rights issues

The Trust has a responsibility to provide healthcare to the community that it serves. Each year we establish community events, to promote the services we offer, and strengthen partnership with voluntary sector inclusion groups. Due to the pandemic, and many community centres being closed, we have continued our engagement by participating and engaging in online meetings.

We are members of the Southampton Hate Crime Network, Romsey Disability Network and Engage with Southampton Council of Faiths and Paul Draycott (Executive Director) continues his work as a Trustee for Chrysalis. We have had guest speakers from different social groups to our Vox Pop (Voice of our people) network events and we hosted the HIOW STP Community engagement event, during Black History Month in October 2020. We continue to work with the Southampton City Council Community Response Group, and also the CCG, attending meetings in regards to the pandemic and making different community groups aware, in particular BAME groups, whom as research shows, have been the most severely impacted in the pandemic.

We are committed to being representative of the community we serve by March 2024. As an equal opportunities employer and with an integrated society, the Trust actively promotes equality and diversity. The Trust has a statutory responsibility to give due regard to the Equality Act 2010 and Human Rights Act 1998. 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:

- Ensures that the organisation has equality objectives that meet the requirement of the Public Sector Equality Duty as set out under the Equality Act 2010.
- Receives and considers regular reports in order to evaluate the effectiveness of the policy
- Reviews the Diversity scorecard that is released annually

The Equality, Diversity and Human Rights Policy provides a framework for Southern Health to meet requirements of the Equality Act 2010 and Human Rights Act 1998. Policies are monitored for effectiveness and ensure they are embedded across the organisation. All policies that are launched, or refreshed, have an Equality Impact Assessment completed.

The Trust has recently refreshed the People and Organisational Development Strategy, which includes key objectives and milestone measures to ensure that all staff are treated fairly. To take forward the Diversity and Inclusion strategy milestones, we have started People Priority Projects, under five themes:

1. Data, Policy and Research
2. Education and Improvement
3. Employee Experience
4. Service User Experience
5. Talent Management.

Bullying and Harassment was a Priority Project during 2020, which included a campaign message that any level of discrimination is unacceptable. This project also ensured:

- Policy and reporting routes have been updated.
- Reports can be made anonymously across 50 different categories.
- All reports are reviewed by the Inclusion team and the victim is contacted by an executive member.
- An Incident Review Group has been created that checks the quality of the outcomes of incidents.

Southern Health is working as part of the local NHS to tackle health inequalities in our communities and

the inequalities which exist in our workforces. This includes the disparities faced by our Black, Asian and Minority Ethnic (BAME) staff and populations, which were brought into stark focus during the COVID-19 pandemic. The Trust is hosting the appointment of two BAME Population and Workforce Programme Managers to drive this work forwards and ensure a consistent, joined-up approach across the local system.

Some of the key priorities for these colleagues are to build on existing work happening within individual organisations to strengthen engagement with BAME workforce and communities, ensure there is an active and influential BAME network in the system, and ensure that the voices of BAME colleagues are heard at Board level and at the heart of decision making. An initial focus of this work has included ensuring more relevant and targeted COVID-19 vaccination campaigns, to increase the uptake of the vaccination amongst the diverse communities in Hampshire and the Isle of Wight.

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 financial year ending 31st March 2021, we had an estimated total carbon footprint of 65,984 tonnes of carbon dioxide equivalent emissions (tCO2e). In 2020 we 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 2020 we recognise that this year's data will in some instances (core emissions) reflect the impact of the global pandemic over the last year, and in other instances (patient and visitor travel and staff commuting) will not reflect the impact of the pandemic on this year's emission. Over the next year the Trust will be developing a Net Zero Strategy which will outline our plan for achieving Net Zero Emissions as well as clearly looking at the impact of the global pandemic over the last year and moving forward.

For a more detailed update, please see our full Sustainability Report in appendix 1.

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:

Ron Shields, Chief Executive

10 June 2021

2. THE ACCOUNTABILITY REPORT

2.1 DIRECTORS' REPORT

Our Trust Board

As of 31 March 2021 our Board is made up of the Chair and nine 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

Appointments to the Board in 2020/21 were made based on a review of the necessary skills, knowledge and experience required on the Board.

Executive Directors		
Name/ title	**Committee responsibilities**	**Biography**
Ron Shields Chief Executive From 08.06.2020	Attended 5/6 Board meetings he was eligible to attend during 2020/21 Attendee of: • Audit, Risk & Assurance Committee (by invitation) • Nominations & Remuneration Committee	Ron has considerable leadership experience with over 20 years as a successful NHS Chief Executive. His 40-year NHS career spans varied roles across physical and mental health, inpatient and community settings. Prior to joining Southern Health, Ron was Chief Executive at Dorset Healthcare University NHS Foundation Trust, where he led the organisation to achieve an overall CQC rating of Outstanding. Ron has also led NHS organisations in London and Northampton. He has a track record of successful and sustainable transformation and integration of services to improve patient outcomes.

Name/ title	Committee responsibilities	Biography
Dr Nick Broughton Chief Executive From 06.11.2017 to 05.06.2020	Attended 1/1 Board meetings he was eligible to attend during 2020/21 Member of: • Finance & Performance Committee • Quality & Safety Committee Attendee of: • Audit, Risk & Assurance Committee • Nominations & Remuneration Committee	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 Board level positions prior to joining the Trust including Chief Executive of Somerset Partnership NHS Foundation Trust from February 2016 to November 2017 and as Medical Director at West London Mental Health NHS Trust between 2010 and 2016. 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.
Paula Anderson Finance Director Finance Director from 05.09.2016	Attended 7/7 Board meetings she was eligible to attend during 2020/21. Member of: • Charitable Funds Committee • Finance & Performance Committee Attendee of: • Audit, Risk & Assurance 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. In 2001 Paula attained an MBA from the Cranfield University and is also a member of the Chartered Institute of Management Accountants.

Name/ title	Committee responsibilities	Biography
Paul Draycott Director of Workforce, Organisational Development and Communications From 20.11.2017 (voting Board role from 14.05.2019)	Attended 6/7 Board meetings he was eligible to attend during 2020/21. Member of: • Finance & Performance Committee (until July 2020) • 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 and 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.
Paula Hull Director of Nursing and Allied Health Professionals From 28.04.2018	Attended 7/7 Board meetings she was eligible to attend during 2020/21. Member of: • Charitable Funds Committee • Finance & Performance Committee (until July 2020) • Quality & Safety Committee • Workforce & Organisational Development Committee • COVID-19 Quality 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
Grant MacDonald Chief Operating Officer From 04.11.2019	Attended 7/7 Board meetings he was eligible to attend during 2020/21. Member of: • Finance & Performance Committee • Quality & Safety Committee • Workforce & Organisational Development Committee • COVID-19 Quality Assurance 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.
Dr Karl Marlowe Chief Medical Officer From 09.04.2018 to 30.04.2021	Attended 6/7 Board meetings he was eligible to attend during 2020/21. Member of: • Quality & Safety Committee • Mental Health Legislation Sub-Committee • COVID-19 Quality Assurance Committee	Karl trained at Liverpool Medical School, Barts and The Royal London, Maudsley Hospital and Guys and St Thomas Hospitals, with postgraduate qualifications from University College London and the Institute of Psychiatry, as well as the Saïd 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). He 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 05.05.2019	Attended 7/7 Board meetings she was eligible to attend during 2020/21. Member 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.

Non-Executive Directors		
Name/ title	**Committee responsibilities**	**Biography**
Lynne Hunt Chair Appointed 03.07.2017 (3 year term) Reappointed 03.07.2020 (3 year term)	Attended 7/7 Board meetings she was eligible to attend during 2020/21. Member of: • Nominations & Remuneration Committee (Chair) • COVID-19 Quality Assurance Committee	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.

Name/ title	Committee responsibilities	Biography
Jeni Bremner Non-Executive Director, Deputy-Chair Appointed 14.07.2017 (1 year) Reappointed 14.07.2018 (3 years)	Attended 7/7 Board meetings she was eligible to attend during 2020/21. Member of: • Audit, Risk & Assurance Committee • Finance & Performance Committee (Chair) • Mental Health Legislation Sub-Committee (Chair from December 2020) • Nominations & Remuneration Committee • Quality & Safety Committee • Workforce & Organisational Development Committee • COVID-19 Quality Assurance Committee	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.
Michael Bernard Non-Executive Director, Senior Independent Director (from 14.07.2020) Appointed 14.05.2019 (3 years)	Attended 7/7 Board meetings he was eligible to attend during 2020/21. Member of: • Nominations & Remuneration Committee • Charitable Funds Committee (Chair) • Quality & Safety 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.

Name/ title	Committee responsibilities	Biography
Kate FitzGerald Non-Executive Director Appointed 14.05.2019 (3 year term)	Attended 6/7 Board meetings she was eligible to attend during 2020/21. Member of: • Nominations & Remuneration Committee • Charitable Funds Committee • Mental Health Legislation Sub-Committee (chair until December 2020) • Quality & Safety Committee (Chair from December 2020) • Workforce & Organisational Development 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.
Robert Goldsmith Non-Executive Director Appointed 01.10.2018 (3 year term)	Attended 7/7 Board meetings he was eligible to attend during 2020/21. Member of: • Finance & Performance Committee • Nominations & Remuneration Committee • Audit, Risk & Assurance Committee • Workforce & Organisational Development Committee (Chair)	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 Hicks Non-Executive Director Appointed 01.01.2018 (3 year term) Reappointed 01.01.2021 (3 year term)	Attended 7/7 Board meetings he was eligible to attend during 2020/21. Member of: • Audit, Risk & Assurance Committee • Nominations & Remuneration Committee • Quality & Safety Committee (Chair until December 2020) • Transformation Steering Committee • COVID-19 Quality Assurance 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.
David Kelham Non-Executive Director Appointed from 14.07.2017 (3 year term) Reappointed 14.07.2020 (3 year term)	Attended 7/7 Board meetings he was eligible to attend during 2020/21. Member of: • Audit, Risk & Assurance Committee (Chair) • Charitable Funds Committee • Nominations & Remuneration Committee Invited to observe: • Finance & Performance Committee • Quality & Safety 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. As CFO of the respective Boards he helped to successfully grow and transform seven organisations, including six PLCs. In 2010 he was nominated by one of the leading accounting firms as 'an outstanding international CFO'. His mother lived with Alzheimer's for 10 years before her death in 2011. His Mother-in-law died in January 2021, again after a long period of dementia. David was honorary Treasurer and Trustee of the Alzheimer's Society from September 2015-March 2017. 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 Tablers' Association.

Name/ title	Committee responsibilities	Biography
Dr Subashini M Non-Executive Director Appointed 19.01.2021 (3 year term)	Attended 2/2 Board meetings she was eligible to attend during 2020/21. *Open invite to attend any Board Committee meetings during induction period.*	Suba is a medical doctor with a special interest in patient-reported outcomes, data science and wellbeing. She currently works at Aviva UK, where she uses her clinical expertise to commission value-based healthcare through co-designing innovative healthcare propositions to address unmet clinical and customer needs. She is passionate about empowering individuals to make informed choices about their care and is driven to make healthcare as inclusive and accessible as possible.
David Monk Non-Executive Director, Senior Independent Director (up to 13.07.2020) Appointed 14.07.2017 (3 year term) Reappointed 14.07.2020 (1 year term)	Attended 7/7 Board meetings he was eligible to attend during 2020/21. Member of: • Finance & Performance Committee • Mental Health Legislation Sub-Committee (Chair) • Nominations & Remuneration 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.

Name/ title	Committee responsibilities	Biography
Ade Williams Non-Executive Director Appointed 12.02.2021 (3 year term)	Attended 1/1 Board meetings he was eligible to attend during 2020/21. *Open invite to attend any Board Committee meetings during induction period.*	Ade is the Director and Superintendent Pharmacist of the MJ Williams Pharmacy Group. He is an Associate Non-Executive Director at the North Bristol NHS Trust and is the Lead prescribing Pharmacist at the multi-award winning Bedminster Pharmacy, an independent Healthy Living Pharmacy in South Bristol. He also works as part of a GP Clinical Team. Widely recognised for his work through national awards including the 2019 NHS Parliamentary Award for Excellence in Primary Care, GP-Pharmacist of the Year 2019 and NHS Pharmacist of the Year 2018. As part of the 2018 NHS70 Parliamentary Awards, he was nominated as the Person-Centred Care Champion. In 2017, alongside being the UK Community Pharmacist of the Year, he was awarded the inaugural Royal Pharmaceutical Society's Patient Champion Award. For distinction in the practice of pharmacy, he received a Fellowship of the Royal Pharmaceutical Society.

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:

- 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.

In 2020/21 the Trust commissioned the Good Governance Institute to undertake a full review against the well-led framework. This is now complete and will help shape the plans for the Board Development programme for the Trust.

Board meetings

The Board met on seven occasions during 2020/21 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. This year they have been held online due to COVID-19 restrictions. Due to the pandemic, only one session was held during the year and discussions focussed on an update on the service user and carer audits, receiving real-time patient feedback and governance during the pandemic.

The Board approved changes to the usual governance arrangements, that took effect from March 2020; these included the use of written motions where appropriate to discharge business; the establishment of regular videoconference calls between the Committee Chairs and Executive Director leads whilst Committees were temporarily suspended; and the establishment of a COVID-19 Quality Assurance Committee and COVID-19 Clinical Ethics Forum.

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 (ARAC)
- Charitable Funds Committee
- Nominations & 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

During 2020/21, to provide additional oversight of decision-making during the COVID-19 pandemic, the following were established:

- COVID-19 Quality Assurance Committee (subsumed into Quality & Safety Committee from 23.06.2021)
- COVID-19 Clinical Ethics Forum

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 four 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 gatekeeping, management of change, temporary staffing, clinical audit, COVID expenditure, key financial systems, ligature management and salary errors. Progress against any actions is monitored and challenged on a regular basis.

In relation to the 2020/21 financial year, the significant issues which the Committee members have considered in relation to the financial statements are the impact of the pandemic on the Trust's finances and the impact of any changes to the requirement of the Board to sign off the Accounts on a going concern basis. The Committee has also had oversight of 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 impact of the pandemic on the Trust's finances has been discussed regularly by the Committee members who have noted the contribution to achieving the breakeven position.

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 and Audit, Risk & Assurance Committee. 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 2020/21 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 October 2020, the Council of Governors ratified the decision to extend the contract for PwC for a further year; 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. In 2021 the Trust commenced the process to tender for the external audit provider for the year ended March 2022. A task and finish group has been formed with Governors and a final decision on the appointment of the external auditors will be approved by the Council of Governors.

Attendance of the members of the Committee is as follows

Name	Meetings (attended/ eligible to attend)
David Kelham (Chair)	4/4
Jeni Bremner	3/4
Dr David Hicks	4/4
Rob Goldsmith	4/4

The Committee received and reviewed a number of different reports during the year which included the Board Assurance Framework and risk reports, COVID-19 Procurement Report, sustainable development action plan, Windows 10 Update, update on digital technology, information governance Annual Report, procurement compliance, Freedom of Information Annual Report, losses and special payments, off-payroll engagements and use of consultancy, quality account, legal services, review of the policy on provision of non-audit services, RIO update, banking arrangements and investment management, standards of business conduct policy, Going Concern declaration and data security and protection toolkit.

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 the 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 service users.

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.

Last year we launched our five year Quality Improvement Strategy which describes what quality improvement means to us and how we are going to deliver sustainable change. The 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.

In 2019/20 we worked closely with our staff to engage them in the change methodology and trained many staff to use it within their teams. Over the last year we have seen numerous examples of this happening in practice as teams implemented new ways of working as part of the Trust's response to the COVID-19 pandemic. Using the learned methodology, staff were able to rapidly adapt services in order to ensure patient and staff safety whilst continuing to deliver care.

The delivery of the Trust's quality 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 which all have clinical representation.

The Trust's Quality & Safety Committee 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, incident reporting, investigations, complaints and patient/ staff feedback. These groups report in to the divisional Quality and Safety Meetings (QSM) which ensure the divisional approach to quality is patient and service user focused at all times.

The Divisional Quality & Safety Meetings are 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 of learning. 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 the Quality & Safety Committee.

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 last 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.

During 2021 we commissioned the Good Governance Institute to undertake a well-led development review; this consisted of interviews with Board members, review of Board and Committee reports, and consideration of the Trust's governance approach. This was completed in May 2021, with a report shared with the Trust Board.

The Executive Directors support services to ensure they are well-led through monthly Executive Performance Group meetings. These are designed to review performance, oversee significant risks and provide a forum for facilitating improvement.

More information on the Trust's approach to implementing the well-led framework can be found within the Annual Governance Statement on pages 108 to 110.

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.

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.

This year we have also been developing a new Quality Dashboard which was implemented from 1 April 2021. This dashboard will be used to guide discussions at the Quality & Safety Committee in relation to patient safety, clinical effectiveness and patient experience, focusing on quality impact rather than pure numerical data. For example moving from number of incidents to rate of harm per 1,000 bed days

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

At the beginning of the reporting year, during the first escalation of the COVID-19 pandemic (April to July), the Trust temporarily paused complaint investigations due to staff redeployment. This was in accordance with advice from NHS England & NHS Improvement regarding the management of complaints at that time.

The Trust continued to triage concerns and complaints for any immediate issues of patient safety, practitioner performance, or safeguarding in order to take immediate action if required. Normal levels of service resumed fully from August 2020.

The Trust has undertaken a full review of the internal complaints process this year and a 10-day timeframe for all cases has been implemented across all services.

The new process has provided further clarity regarding the management of complaints within the organisation and has reinforced the approach that the senior leadership teams within the Divisions are responsible for leading on complaints. The expectation is that they will look into the issues raised, and respond to the feedback received in a timely way, while maintaining effective engagement with the person who has raised concerns.

Our aim is to improve staff engagement regarding complaints, whilst promoting and strengthening early local resolution where this is possible. In doing so, this will help to ensure the people who contact us for help and support regarding their concerns feel listened to and are reassured that the issues they have raised, are taken seriously. The central Complaints and Patient Experience Team are supporting the Divisions in a coaching capacity and as subject experts regarding the complaints process and statutory regulations. The team are fulfilling an important quality checking role and challenging cases as required from a 'critical friend' perspective.

We also now routinely share complaint investigation reports with all complainants, to help facilitate openness and transparency regarding the process and our management of cases. In doing so we have made key information regarding the findings of the investigation, identified learning and agreed actions more accessible to the person making the complaint.

The Complaints and Patient Experience Advisors make follow up telephone calls to all complainants within a month of their case closing to gain feedback regarding their experience of the complaints process and their engagement with Trust staff. This is a valuable learning exercise from a qualitative perspective, with the outcome of the conversations saved to cases. Any additional issues or queries raised at this stage are progressed with the relevant clinical service if requested by the complainant.

Staff in the complaints team are working closely with the Divisions in a business partner model with weekly oversight meetings, to gain assurance that the new process is being followed and the 2009 Local Authority and NHS Complaint Regulations are observed at all times. The team also provide Customer Care training to all staff and Investigating Officer training to staff within the clinical services, in addition to bespoke training courses as and when requested.

The Trust has applied to participate in the Parliamentary and Health Service Ombudsman, Complaint Standards Framework Pilot for the NHS in England. The Framework will be supported with detailed practical guidance and a comprehensive training and development program, leading to certificated/accredited courses. We are awaiting the outcome of our application and are committed to undertaking this important piece of work with the Ombudsman, if we are successful in our application, from Spring this year.

Patient experience framework

In July 2020 we received the results of an audit, carried out by BDO, of our patient experience approach (which includes our work to involve carers and families). The audit was conducted against an evidence-based NHS Improvement framework linked to CQC themes, which is designed to enable Trust Boards and senior teams to continuously improve patient and carer experience.

The audit authors commented positively on what they described as *"significant levels of service user*

engagement", highlighting the People and Partnership Commitment, Families, Carers and Friends Group, and the Working in Partnership Committee.

The audit concluded that: *"…processes relating to patient engagement and experience are well embedded with particularly strong controls in place regarding service user engagement. The inclusion of Service User Facilitators and Experts by Experience has increased the levels of involvement with service users and carers and enabled valuable insight.*

"There are good levels of co-production and the complaints process was found to be well developed and aligned to the requirements of the Patient Experience Improvement Framework. However, some areas of improvement were identified such as in the process of analysis and triangulation of patient feedback where it was felt there were still difficulties in collating information into a central point."

Patient experience audits

We have now implemented robust feedback and audit systems. Quarterly audits/patient surveys are undertaken across all our services, including a co-designed carers survey. The audit questions are based on Service User Led standards and CQC recommendations. All information will be collated into a central point and improved software will improve the process of analysis and triangulation of results.

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, unless otherwise disqualified from membership by the Constitution.

As of 5 May 2021 there were 7,717 active public members of the Trust.

Public membership numbers by constituency:

	2020/21	**2019/20**
North Hampshire	1,580	1,730
South East Hampshire	1,166	1,234
South West Hampshire	2,301	2,501
Southampton	1,718	1,861
Rest of England	952	1,015
Total	7,717	8,341

Whilst we are disappointed to see a decrease in public membership in 2020/21, this is reflective of the limited recruitment and engagement activity undertaken due to the pandemic. Re-energised plans are in place to further grow and engage in with our membership for 2021/22 and beyond.

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.

A map to show the constituency areas for our membership:

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. From March 2021, the Working in Partnership Committee took over responsibility for active monitoring and growing of the Trust membership through the engagement strategy. Through its meetings the Working in Partnership Committee will monitor the membership to ensure that it is representative of the population, and to identify areas that would benefit from additional engagement activity.

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 Council of Governors can be found at: https://www.southernhealth.nhs.uk

Our Council of Governors consists of 22 members. As at 31 March 2021 there were 18 Governors in post on the Council of Governors and four vacancies (in our South West Hampshire, Southampton and South East public Constituencies, as well as one Appointed Governor vacancy):

- 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 feedback 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 Council of Governors 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 until 24.07.2020)	25.07.2011	24.07.2020	3	1/1
	Paul Lewzey	02.08.2018	01.08.2021	1	2/3
	Stephanie Angell*	23.03.2021	22.03.2024	1	0/0
South West Hampshire	Josephine Metcher	21.07.2015	20.07.2021	2	2/3
	Peter Smith	05.11.2018	04.11.2021	1	3/3
	Russell Stevens*	29.06.2020	21.01. 2021 (Resigned)	1	3/3
North Hampshire	Venus Madden	13.10.2016	14.01.2023	2	3/3
	Keith Chapman*	23.03.2021	22.03.2024	1	0/0
	Sarah Pearson*	23.03.2021	22.03.2024	1	0/0
South East Hampshire	Gary Butler*	17.05.2017	16.05.2020	1	0/0
	Suzanne Pepper	01.07.2019	30.06.2022	1	3/3
	Robert Blackman*	18.12.2019	18.12.2020 (Resigned)	1	2/2
	David Gary*	23.03.2021	22.03.2024	1	0/0
Rest of England	Michael North	01.07.2019	30.06.2022	1	3/3

* in post for part of the year

A term of office for an 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*	08.08.2017	07.08.2020	1	1/1
	Sarah Reed*	23.03.2021	22.03.2024	1	0/0
North Hampshire	Louise Vinell	22.10.2018	21.10.2021	1	2/3
Southampton	Sally-Ann Jones*	23.03.2021	22.03.2024	1	3/3
South East Hampshire	Ali Wileman*	11.05.2020	10.05.2021 (Resigned)	1	3/3

* 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 (Lead Governor from 25.07.2020)	01.03.2016	28.02.2022	2	3/3
Hampshire County Council	Cllr Rob Humby	21.11.2017	28.03.2024	2	3/3
Southampton City Council	Cllr Lorna Fielker	06.12.2018	05.12.2021	1	2/3
University of Southampton	Prof David Baldwin	13.04.2017	10.05.2023	2	2/3
Age Concern Hampshire	Vacancy				

* in post for part of the year

Further information on the work of the Council of Governors is provided on page 60.

Our Lead Governor

Adrian Thorne took over the role of Lead Governor from Andrew Jackman with effect from 25 July 2020 until the end of his term (February 2022). In his role as Lead Governor Adrian has attended Trust Board and Board Committee meetings, held discussions with Governors in private, and where required, brought matters to the attention of the Chair to raise any issues or to seek clarity. He has also attended a number of externally held conferences.

Governor elections

Elections were held in January 2021 where a number of new Governors were elected, as set out in the table on pages 60 and 61. As of 31 March 2021, 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 Council of Governors and the Trust Board. There are regular opportunities for Governors to meet with Non-Executive Directors, Directors and Trust staff through Governor Development days, Council of Governors' meetings, or on a collective/ individual basis with either the Chair or the Senior Independent Director if they wish.

In 2020/21, we held three confidential meetings between the Governors and Non-Executive Directors. Open and honest discussions were held around the impact of the COVID-19 pandemic on service users, patients, carers and their families, as well as on staff, services, the Trust and wider NHS.

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 Council of Governors and Board have worked together this year include:

- confidential meetings between Governors and Non-Executive Directors
- Executive and Non-Executive Directors attending Council of Governors meetings
- reports presented by Governors to each Council of Governors meeting summarising their observations following attendance at Committee meetings
- Governors invited to attend the confidential session of Trust Board meetings (in addition to the public sessions)
- Council of Governors receiving the agenda and minutes of the public and confidential Trust Board meetings
- Governors being invited to observe and give feedback at all Board Committee meetings (with the exception of the Nomination & Remuneration Committee and the Executive Management Committee).

In 2020/21 the Council of Governors has:

- received family and carer stories
- received updates on the impact of the COVID-19 pandemic on service users, patients, staff and the Trust
- reviewed and approved the Lead Governor nomination and election process
- approved the reappointment of Dr David Hicks as Non-Executive Director, for a three-year term, with effect from January 2021
- approved the appointment of Subashini M and Ade Williams as Non-Executive Directors, each for a three-year term
- approved the extension of the contract with PricewaterhouseCoopers for a further year.

In 2020/21 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 Council of Governor meeting to obtain information about the performance of its functions or the directors' performance of their duties. If any disputes arise between our Council of Governors and Board of Directors, then the disputes resolution process as described in the Trust Constitution would be followed. During 2020/21, this process has not been required.

Appointment Committee

The Council of Governors has established an Appointment Committee to recommend the appointment of the Chair and Non-Executive Directors to the Council of Governors, including recommendations on remuneration. The committee membership is made up of Governors and a Non-Executive Director (usually the Chair). Governors have an open invite to become a member of the Appointment Committee should they wish.

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 Council of Governors 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 2020/21 and attendance of Governors at the meetings is as follows:

Name	Meetings (attended / eligible to attend)
Lynne Hunt, Chair	3/3
Venus Madden, Public Governor, North Hampshire	2/3
Josephine Metcher, Public Governor, South West Hampshire	2/3
Michael North, Rest of England	3/3
Suzanne Pepper, South East Hampshire	1/1
Adrian Thorne, Appointed Governor, Carers Together	3/3
Ali Wileman, Staff Governor, South East Hampshire	3/3

Chair and Non-Executive Director appointments and remuneration

In 2020/21, the following recommendations made by the Appointment Committee were approved by the Council of Governors:

- the appointment of Subashini M and Ade Williams as Non-Executive Directors; and
- the re-appointment of Dr David Hicks as a Non-Executive Director

Our Constitution sets out the process for decisions on appointment and remuneration of Board members. It defines the criteria by which a Board member may not continue in the role and also outlines additional provisions for the removal of the Chair and Non-Executive Directors. A proposal to remove a Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors. If any proposal to remove a Non-Executive Director is not approved at a meeting of the Council of Governors, no further proposal can be put forward to remove the Non-Executive Director based upon the same

reasons within 12 months of the meeting.

Involving our stakeholders

As well as our members and Governors we have a strong programme of work to engage with all our key stakeholders and the wider community. We are continuing to work to our 'Commitment to working with people plan 2018/2022' which 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, families and staff are based on compassion, respect and shared decision-making that leads to people feeling fully involved in their own are 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.

Below are a number of examples where we have worked with patients and service users to make improvements to our services:

Review of our use of rapid tranquilisation

Our Consultant Nurse and Clinical Lead for Learning Disabilities carried out a comprehensive review of the use of Rapid Tranquilisation with the aim of setting out the future approach for Southern Health in the administration and management of rapid tranquilisation.

A review was undertaken of current practice relating to rapid tranquilisation and data covering a six month period was obtained and analysed to support this. Patient views were sought to support the development of appropriate recommendations and the actions required. A number of patients participated in the project through face to face interviews to ensure the patient could be heard and had time to give their feedback and suggestions.

The recommendations were fully supported and approved by the Trust board. The review concluded that positive and pro-active strategies should be consistently evident in order to reduce the need for rapid tranquilisation, with this only being considered when all attempts at de-escalation have been exhausted.

There are a number of quality improvement projects currently underway to support this, which have already had a positive impact in reducing the numbers of incidents involving rapid tranquilisation.

In addition, where rapid tranquilisation is required this will be able to be given in the thigh site and through clothing which provides a more dignified option and allows the person to be seated for administration, reducing the need for prone restraint. The Trust policy and associated training has been reviewed to reflect the changes in practice.

Improvements in patient/carer information

During the last year we have worked in co-production with our service users, patients, families and carers to improve our information and communication. Our Trust-wide consultative Working in Partnership group and our Families, Carers and Friends group have reviewed a number of patient information leaflets. This includes leaflets on sepsis, catheter information and antibiotic awareness. These groups were also

involved in the review and update of our Accessible Information policy.

As part of the Triangle of Care accreditation, we aim to provide clear information and guidance that is useful and meaningful to carers. As such we are developing carers booklets for each service and team. The carers booklets have been developed in full collaboration with carers, through teams and carers groups, our partner services such as the voluntary and community sector, local authorities in our geographical areas and national organisations such as Dad's Pads.

In response to feedback from our carers via carers zoom sessions we have also produced a Confidentiality and Information sharing booklet.

Our Carers Information web pages have been constantly updated with signposting information this last year due to the pandemic. We have ensured that information about support services, helplines etc. are on the web page and we have also produced a document for both staff and carers containing contact details for a range of support services across Hampshire.

We have established 'The Expert by Experience Easy Read Group'. Our service users initially met monthly and quickly produced lots of easy read information that was required. The group now produces information for other areas in the Trust, e.g. older people's services, communications team. Our service users are paid for this work and have a separate email for work requests. Our Service User Involvement facilitator ensures that all leaflets and factsheets are reviewed by service users and patients. For example, our Mental Health Act leaflets have been produced to be child friendly.

Further examples of service improvement/service change can be found in our Patient Insight reports which are published quarterly on our website (www.southernhealth.nhs.uk).

Volunteering during COVID-19 pandemic

At its height we utilised the services of over 100 volunteers (May 2020). Most help was in the delivery of PPE across the county. Volunteers delivered five days a week from six hubs under the co-ordination of the volunteer and PPE (Personal Protective Equipment) teams. Volunteers were also used to deliver wellbeing and food products, lift and shift equipment, support for the IT team and the 'Tree of Life Café' zoom gatherings.

Apart from recruiting our own volunteers we used the services of established groups and charities to support patients and people who had used our services recently. The main organisations were:

- Member organisations of the Hampshire CVS network
- Age Concern Hampshire
- Good Neighbours network
- Totton and Eastleigh Timebanks

These groups provided shopping for essential goods, telephone calls for those isolated or shielding, prescription collection, hot meals and transport to medical appointments.

Community Engagement

Despite the lockdown the in-house projects to create more healing open spaces in and around our hospital and unit estates progressed. Young people at Austen House are working on designs for various pieces of art for the meadow area at Tatchbury, while plans are underway to start work on the garden area at the Mother and baby unit, Melbury Lodge.

With the Tatchbury 'brightergrounds project' we have been working in partnership with the New Forest National park. The National Parks in the UK provide support for health and wellbeing and in July we engaged with the South Downs National park to explore healthy walks and recovery from illness.

Our work and relationship with 'Time 4 Hampshire' (Hampshire Timebank) and the Men's Shed movement continues to develop. In March we co-founded the Eastleigh Borough Timebank and hope that it will provide a place where the people we support in that area can share their skills and receive something back

in the form of friendship, learning a new skill or receiving help.

We have supported the new Men's Shed in Liss, Petersfield, to start work on its new meeting place or 'shed'. The group have a specific aim to look out for and engage with those who are isolated and/or in poor health.

We have been working with the St. Denys Activity group, a non-profit organisation which aims to improve mental health and wellbeing by providing activities which offer mutual support, good times and a listening ear. Last year the group had a tour of Antelope House and were able to chat to staff and ask questions. During the COVID-19 lockdown we were aware that St. Denys Activity Group service users were getting anxious because all the support groups they access had shut down. Some commented that they felt isolated. Quite a number relied on support groups and drop-ins for meals. In addition, we were getting information that the mental health of some of the members had been negatively impacted. Winter was also challenging due to increase heating costs coupled with isolation caused by the pandemic. With this in mind, the St Denys Activity Group committee explored ways in which they could keep in touch with members so that they knew someone was there for them.

Through our charity Brighterway, we were able to support St.Denys Activity Group to provide hot meals for the most vulnerable in the community. Since the project began, they have provided a total of 105 meals. In addition to this we delivered 51 meals to vulnerable elderly members of the community. Half the people we delivered meals to were our service users who were unable to collect and the others were isolated elderly BAME people who we knew accessed the luncheon club which has been closed due to the pandemic. A few of our service users live with their partners or family members who are their carers and additional meals were provided when required.

Our work to support carers and families

Southern Health is working towards the Triangle of Care accreditation (through Princess Royal Trust for Carers and the Carers Trust). The aim of Triangle of Care is to acknowledge the importance of three key stakeholders for health and social care: service users, staff and carers. The main focus is on how we better work together with carers, families and friends to the benefit of the service user and reduce risks of carers becoming future service users.

We are pleased to report that we have now submitted our Triangle of Care self-assessment documents for star one accreditation in January 2021. This included self-assessments for all of our 33 inpatient wards for AMH (Adult Mental Health), OPMH (Older Persons Mental Health), Learning Disabilities, Forensics and CAMHS. We await the response from the Princess Royal Trust for Carers in Hampshire (PRTC) on behalf of the Carers Trust.

In response to the six principles of the Triangle of Care, the Trust has adopted the following four standards for our work with carers: Carers Leads, Carers Booklets, Triangle of Care training and Carers Communication Plans.

The following is an update on each standard:

Carers Leads - We co-developed the role of Carers Leads alongside staff and carers. Their main aim is to encourage and support their colleagues to better engage, communicate with and support carers. We currently have over 150 Carers Leads within all teams across our services, and many of our Heads of Nursing and AHPs (Allied Health Professionals) and Divisional Directors have taken ownership and leadership of the Triangle of Care within their services as Carers Leads for their divisions.

Carers Booklets - We have co-produced 12 carers booklets with carers. 14 other teams are working on draft wording for their booklets.

Triangle of Care training - has been redeveloped alongside carers and Carers Leads over the summer of 2020 and the training relaunched in November 2020. During February and March 2021, the Board, Divisional Directors, Heads of Nursing and AHPs and Matrons completed the training. This will be extended to all staff in Quarter 1 2021/22.

Carers Communication Plans - are increasing across the Trust with 47% of our identified carers having them in place. Amendments to the Carers Communication Plan will be complete by April 2021. This should also increase the use of them across the Trust.

Stakeholder relations

We provide a diverse range of services to a large population over a wide geography. Many individuals, groups and organisations are affected by, 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. 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. Although the pandemic has limited the number of visits we have hosted this year we were pleased to welcome MPs to open our new garden at Parklands Hospital in Basingstoke, and the opening of our new forensic Learning Disabilities unit, Ashford, over the last 12 months.

Southern Health plays a key role in the local health and care system and works closely with stakeholders from local organisations. Senior colleagues from the Trust attend and contribute to strategic meetings at a local care partnership and system level to ensure joined up planning and delivery of services across different organisations. The Trust's Chief Executive chairs the Hampshire and Isle of Wight (HIOW) Mental Health Partnership Board and is a member of the HIOW Health and Care Leadership Group.

We carry out an annual audit of our stakeholders' attitudes towards the organisation. The results for 2019/20 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 results for 2020/21 showed a further improvement in attitudes, although it is important to be clear that the audit took place during the pandemic and the response rate was considerably lower than the previous year. The audit also provides useful feedback on where we can improve our stakeholder engagement, which we have acted upon and hope to see reflected in the results for the year ahead.

In addition to this regular audit, in Q4 2020/21 we also commissioned an external organisation to carry out a further stakeholder questionnaire and interviews to gain a deeper understanding. This will provide additional insights to help us further improve our communications and involvement of our stakeholders.

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 commissioners 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 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.
- The Hampshire and Isle of Wight Integrated Care System (ICS) which is a partnership of NHS and local

government organisations working together to improve the health and wellbeing of our local communities. It is one of the largest health and care systems in the country with a long history of working with our population and each other to make lives better. Southern Health is a key partner in this system as the largest mental health and community Trust in the partnership.

We continued our partnership work with Unloc despite the impact of COVID-19 which meant that we were not able to deliver workshops in schools and colleges. However, we adapted and introduced innovative ways to continue this work. Unloc and Southern Health worked together to provide a meaningful alternative to the provision that was to be delivered in a digital format.

For example, we created a bespoke mental health and wellbeing online course free for all students to access. The course focuses on four key themes.

- What is mental health?
- What is wellbeing?
- Understanding your own mental health and wellbeing
- Good mental health and wellbeing practice.

We were also delighted that we have now established a Youth Board who have planned further workshops and webinars on mental health awareness. The young people will also be working with us on attracting more young people to become members and have greater involvement in health.

- 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.
- The Depth of Me project aimed to listen and engage with patients and carers about their experiences of using health services and the impact these experiences have on their lives, using photography and poetry as the medium for participants to share their story. We delivered the project in partnership with Hampshire Cultural Trust, In Focus, SoCo (poetry people) and Drop the Mask, a Southampton Community Interest Company. Drop the Mask have produced a documentary on the project which can be viewed on our communication and social media channels. In July we held a virtual launch of the exhibition and were able to showcase some truly inspirational pieces of work. We have captured over 60 pieces of feedback on the project from staff and participants and every single piece has been positive.
- We also work with cultural groups within our geography. The St Denys Activity Group and The United Voices of Africa Associations (TUVAA) BAME project set out to explore why BAME service users fail to access mental health support groups or other groups. Work so far includes:
    - Peer Support Training on Zoom. The peer support training was provided by Mind Charity. It is anticipated that the training would help develop support groups within the BAME communities in future.
    - Meetings with TUVAA to: establish how we are going to approach community engagement and establish a client pool for the focus groups. We have jointly agreed the methodology of the research and collated interview questions.
    - Securing the support of SAWA (Southampton African Women Alliance).
    - St Denys Activity Group is a member of Southampton Mental Health Network (SMHN) which aims to make Southampton more Mental Health Friendly and inclusive.
- We are currently engaged with the Hampshire Together programme of work which includes the proposal to build a new hospital in Hampshire. The Hampshire Together team are involved with our Working in Partnership group and members have attended engagement meetings.
- Southampton Health Overview and Scrutiny committee are currently reviewing work with carers in the city with a view to making recommendations to be included in a refreshed strategy for the city.

We have been part of this review and have presented our work with carers to ensure a joined up approach and sharing of good practice. We are members of both the Hampshire Partnership Board for Carers and the Southampton Partnership Board

- 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 91.

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 unaware 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.

Fees and charges

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

Political and charitable donations

We have not made any political or charitable donations during 2020/21.

Better payment practice code

	31 March 2021 YTD number	31 March 2021 YTD £'000	31 March 2020 YTD number	31 March 2020 YTD £'000
Non NHS				
Total bills paid in the year	29,603	101,866	37,497	109,226
Total bills paid within target	27,619	97,674	35,211	105,592
Percentage of bills paid within target	93.3%	95.9%	93.9%	96.7%
NHS				
Total bills paid in the year	2,324	23,034	2,483	31,739
Total bills paid within target	1,898	21,087	2,064	28,183
Percentage of bills paid within target	81.7%	91.5%	83.1%	88.8%
Total				
Total bills paid in the year	31,927	124,901	39,980	140,965
Total bills paid within target	29,517	118,761	37,275	133,775
Percentage of bills paid within target	92.5%	95.1%	93.2%	94.9%

The target is to pay 95% of invoices by volume and value within 30 days. 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 £42k (£32k in 2019/20); however, the total amount of interest charged was nil (nil for 2019/20).

Modern Slavery Act 2015

The Trust has published a statement of compliance with the Modern Slavery Act 2015 which is available on our website (www.southernhealth.nhs.uk).

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:

Ron Shields, Chief Executive

10 June 2021

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 2020 and present to you the Annual Report on remuneration for the financial period 2020/21 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 2020/21

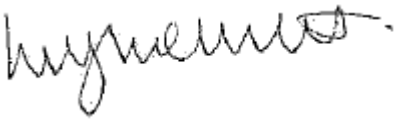
The Nominations & Remuneration Committee aims to ensure Executive Director remuneration is set appropriately, taking into account relevant market conditions. Executive Directors should be appropriately rewarded for their performance against goals and objectives linked directly to the Trust objectives, 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 and responsibilities with Southern Health. There have been no substantial changes in senior management remuneration agreed in the year.

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

- the appointment and remuneration of the Chief Executive;
- the temporary pay increase for the staff at Crowlin House;
- the appointment and remuneration of the Medical Director; and
- the Very Senior Manager inflationary pay increase in line with the national recommendation.

Signed:



Lynne Hunt, Chair

10 June 2021

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, bonuses (if applicable) or earn back, the provisions of other benefits, the approval of arrangements for termination of employment and other major contractual terms.

The Executive Director Remuneration Policy was last 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, the Foundation Trust duties under the Equality Act 2010 and the Public Sector Equality Duty and takes account of the national pay framework and terms and conditions applied for all staff across the Trust.

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 Foundation Trust (£200m-£400m 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 Managers.

All remuneration decisions will need to take into consideration affordability. There is no standard bonus related pay scheme for Executive Directors, but for some Executive Director roles (including the Chief Executive) the earn-back element and/or bonus is included as part of their remuneration package depending on Nominations & Remuneration Committee approval. All salaries over £150k are subject to NHSE/I approval - this applies to two positions on our Board.

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 have oversight of workforce remuneration by annual review.

The Workforce Remuneration Policy sets out for all other employees 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 Chair and Non-Executive Director Remuneration Policy is used for determining remuneration and allowances for the Chair and Non-Executive Directors. It recommends the use of the NHSE/I document

'Structure to align remuneration for chairs and non-executive directors of NHS Trusts and NHS Foundation Trusts'. The Chair and other Non-Executive Directors are not employees and their remuneration is set by the Council of Governors.

Senior Managers' Remuneration Policy table

The 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.

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. There are no new components or changes made to existing components of the remuneration package in year other than as detailed below.

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. An Earn Back clause of up to 10% of base salary was agreed for salaries over £150k. This is in line with NHSE/I requirements. This is explained in the "Executive Remuneration Policy" as follows: "If the agreed performance objectives have not been met, base salary may be reduced and the difference recovered over an agreed period following the performance review. If the agreed performance objectives have been met the individual will qualify to 'earn-back' the element of their base salary put at risk each month and it will not be recouped. The enforcement of earn back will be determined using the following process: • Performance against the Trust's annual objectives will be reviewed annually during your annual appraisal, and the outcome of this review will be shared with the Trust's Nominations and Remuneration Committee (NRC). • In the event of substantial and/or sustained under performance against the annual objectives, the NRC may choose to exercise its discretion to recover up to 10% of annual salary.

	• In the event that the NRC decide to enact earn back arrangements, people will be fully consulted on the mechanism before implementation. • Should someone leave during a period when money is being retrieved through Earn Back; any outstanding amount will be deducted from their final salary" The reference period for the calculation of earn back, or performance related pay, is based on the individual's date of appointment. There were earn back arrangements in place for the Chief Medical Officer and both the former and current Chief Executives which have not been invoked. The current Chief Executive's overall remuneration package also includes an element of performance related pay of 10% (as agreed with NHS Improvement) which, if fully achieved, will result in total annual remuneration which is consistent in value with the former postholder.
Description of framework used to assess performance	Each Very 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 Chair	£15k	2/3 days a month	4 months
Senior Independent Director	£15k	2/3 days a month	4 months
Audit, Risk & Assurance Committee Chair	£15k	2/3 days a month	4 months
Chair 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.

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 one's 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.

Directors with remuneration (total) greater than £150k

Where remuneration for senior managers exceeds £150k, the Trust takes steps to satisfy itself that any such decision is reasonable by:

- Regularly benchmarking remuneration across peer UK NHS organisations and in liaison with NHS England / Improvement;
- Continuing to seek the opinion of the Department of Health via NHS Improvement for any posts with remuneration exceeding £150k.

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.

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 – End Date (Where applicable)
Chief Executive	06 November 2017 – 06 June 2020
Chief Executive	08 June 2020
Director of Strategy and Infrastructure Transformation	05 August 2019
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

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 twice during 2020/21 and also transacted business via approval of a written motion in April and May 2020 and in March 2021. 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 (Chair)	2/2
Michael Bernard, Non-Executive Director	2/2
Jeni Bremner, Non-Executive Director	2/2
Kate FitzGerald, Non-Executive Director	1/1
Rob Goldsmith, Non-Executive Director	2/2
Dr David Hicks, Non-Executive Director	2/2
David Kelham, Non-Executive Director	2/2
David Monk, Non-Executive Director	2/2
Dr Subashini M, Non-Executive Director	0/0
Ade Williams, Non-Executive Director	0/0

Although not members, Directors and Officers attended the Nominations & Remunerations Committee to provide information and advice when required. The Chief Executive, 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 participated as a member of the Committee for those decisions relating to the appointment of the Medical Director.

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 e.g. "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	2020/21	8	7	8,900
	2019/20	8	7	13,300
Non-Executive Directors	2020/21	10	5	2,500
	2019/20	8	7	15,200
Governors	2020/21	23	3	800
	2019/20	21	9	6,000
Total	2020/21	41	15	12,200
	2019/20	37	23	34,500

Senior manager remuneration and benefits *(information subject to audit)*

Calculations for senior manager Disclosures 2020/21:

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 2021 c (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 d (bands of £5,000)	Cash Equivalent Transfer Value at 01 April 2020 e £ 000's	Real Increase in Cash Equivalent Transfer Value f £ 000's	Cash Equivalent Transfer Value at 31 March 2021 g £ 000's
Paula Hull	2.5-5	2.5-5	45-50	100-105	812	53	897
Dr. Karl Marlowe	0-2.5	0-2.5	45-50	125-130	879	37	948
Heather Mitchell	2.5-5	0	25-30	0	250	23	295

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 scheme. The benefits and related Cash Equivalent Transfer Values disclosed do not allow for any potential future adjustments that may arise from this judgement.

Final summary 2020/21:

Name and title	Office	2020/21					
		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 2	Non-Executive Director	10-15	0	0	0	0	10-15
Kate FitzGerald	Non-Executive Director	10-15	0	0	0	0	10-15
Ade Williams	Non-Executive Director	0-5	0	0	0	0	0-5
Dr Subashini M	Non-Executive Director	0-5	0	0	0	0	0-5
Dr Nick Broughton 1	Chief Executive	40-45	300	0	0	0	40-45
Ron Shields	Chief Executive	145-150	6,000	0	0	0	150-155
Paula Anderson 1	Finance Director	145-150	100	0	0	0	145-150
Paul Draycott 1	Director of Workforce, OD & Comms	115-120	1,500	0	0	0	115-120
Paula Hull 1	Director of Nursing and Allied Health Professionals	125-130	300	0	0	50-52.5	180-185
Dr Karl Marlowe 3,4	Medical Director	180-185	0	0	0	32.5-35	215-220
Grant Macdonald	Chief Operating Officer	135-140	1,000	0	0	0	135-140
Heather Mitchell	Director of Strategy and Infrastructure Transformation	120-125	100	0	0	42.5-45	165-170

1. The amount disclosed for 2020/21 excludes very senior manager pay increase relating to 2019/20 and paid during in 2020/21. All relevant directors each received £0-5k
2. The amount disclosed for 2020/21 excludes contractual payment relating to 2019/20 and paid in arrears in 2020/21, £0k-£5k
3. This officer opted out of the NHS Superannuation scheme during 2020/21 financial year on 31/12/2020.
4. Dr Karl Marlowe's remuneration includes the allocation of two clinical programmed activities related to his clinical role, £25k-£30k (2019/20 £25k–£30k).

Median Pay Multiplier (Information subject to audit)

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 £180k–£185k and results in a ratio of 5.82 (2019/20 the band £210k–£215k and ratio 6.92)

- In 2020/21 no employees received remuneration in excess of the highest-paid director, (2019/20, nil).
- The median pay calculation is based on the payments made to staff in post on 31 March 2021.
- The reported salary used to estimate the median pay is the gross cost to the Trust, less employer's pension and employer's 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 2021 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 and bank staff. All agency and bank staff expenditure is processed through dedicated account codes on the financial system. The total March 2021 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 £31.4k from £30.7k 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.
- The median pay multiplier has decreased principally due to the highest paid director salary reducing in year from mid point £212.5k to £182.5k.

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.

Payments for loss of office (information subject to audit)

The Trust has not made any payments for loss of office in 2020/21 or 2019/20.

Payment to past Senior Managers (information subject to audit)

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:

Ron Shields, Chief Executive

10 June 2021

2.3 STAFF REPORT

As at 31 March 2021, the Board of Directors consisted of seven Executive Directors (four male and three female) and 10 Non-Executive Directors (six male and four female).

As at 31 March 2021, excluding Executive Directors, the Trust had 6,440 employees (1,104 male and 5,336 female.) This does not include agency staff. The Whole Time Equivalent number of staff is 5,553.

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 *(information 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	2020/21 Total £ 000's	2019/20 Total £ 000's
Salaries and wages	190,243	2823	193,066	172,392
Social security costs	18,013	-	18,013	16,438
Apprenticeship levy	917	-	917	841
Employer's contributions to NHS pension scheme	34,408	-	34,408	31,799
Pension cost – other	62	-	62	62
Termination benefits	90	-	90	366*
Temporary staff	-	31,657	31,657	26,802
Total gross staff costs	243,733	34,480	278,213	248,700
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	243,733	34,480	278,213	248,700
Of which: Costs capitalised as part of assets	644	155	799	1,073

*The cost stated for 2019/20 was £59k, this has been corrected to £366k, all of which relates to permanent staff

Average number of employees (WTE) *(information subject to audit)*

	Permanent number	Other number	2020/21 Total number	2019/20 Total number
Medical and dental	236	41	277	251
Ambulance staff	1	1	2	-
Administration and estates	1,394	32	1,426	1,360
Healthcare assistants and other support staff	1,243	249	1,492	1,515
Nursing, midwifery and health visiting staff	1,730	150	1,880	1,794
Scientific, therapeutic and technical staff	611	19	630	560
Total average numbers	5,215	492	5,707	5,480
Of which: Number of employees (WTE) engaged on capital projects	14	3	17	17

Reporting of compensation schemes – exit packages 2020/21 *(information 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	-	16	16
£10,000–£25,000	-	2	2
£25,001–£50,000	-	-	-
£50,001–£100,000	-	-	-
£100,001–£150,000	-	-	-
£150,001–£200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	18	18
Total cost (£)	-	£90,000	£90,000

Reporting of compensation schemes – exit packages 2019/20 *(information 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	-	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

Exit packages: Non-compulsory departure payments *(information subject to audit)*

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 2020/21.

	2020/21		2019/20	
	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	1	5	3	63
Early retirements in the efficiency of the service contractual costs	-	-	–	–
Contractual payments in lieu of notice	17	85	20	130
Exit payments following Employment Tribunals or court orders	-	-	–	–
Non-contractual payments requiring HMT approval	-	-	–	–
Total	18	90	23	193
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 2020/21 the Trust spent £3,000 on consultancy support compared to £59,000 in 2019/20.

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

Staff turnover

Information on our staff turnover can be found on the following website: https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/leavers-and-joiners

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 2020/21 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 highly paid off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months:	
No. of existing engagements as of 31 March 2021	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.	0
No. that have existed for between three and four years at time of reporting.	2
No. that existed for four or more years at time of reporting.	0

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater.	
No. of off-payroll workers engaged during the year ended 31 March 2021	4
Of which : Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	1
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	3
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

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3. For any off-payroll engagements of board members, and/ or, senior officials with significant financial responsibility, between 1 April 2020 and March 2021:	
Number of off-payroll engagements of board members, and/ or, senior officials with 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 enabling staff with disabilities

The Equality Act 2010 places a statutory obligation on Southern Health to protect the equality, diversity and inclusion of all its staff under nine protected characteristics, including 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 is at the heart of everything that we do.

Our Vox Pop (Voice of Our People) networks continue to thrive and be a vibrant source of inclusion and diversity innovation. Our network Co Chairs enable the groups to be more community led. With a revised Equality Standard and the launch of our disability passport in the coming months, this will further enable improved experience and representation for staff with disabilities.

Ally training is now run on a monthly basis, with our Southern Health Inclusion Allies increasing in membership. More Allies will enable us to amplify Inclusion and provide a broader platform for the seldom heard groups to have their voice. We have embedded and continue to update unconscious bias training within Leadership Essentials, Management Essentials and Inclusive Leadership courses.

Due to the pandemic, there has been no face to face engagement sessions or meetings with the Hampshire Disability network groups we work with, but we continue to work with and have attendance at meetings. We have also co-delivered bespoke sessions for teams with colleagues that have learning disabilities, alongside subject experts.

Priority People Projects help give focus to progressing key elements of our People and Organisational Development Strategy. Having Priority Projects, including a policy review, talent management and service user experience, will enable us to look critically at our support for staff from all equality strands, including staff with disabilities.

Our refreshed Diversity and Inclusion strategy is focused on embedding a culture capable of fulfilling our purpose of attracting and retaining great people. These priority projects place a focus on key areas that have been identified as needing improvement. We want to offer a clear pathway of employment for people with lived experience and learning disability, this will be measured by having an in-house supportive employment scheme in place, encouraging lived experience and Learning Disabilities client recruitment within the trust. Our Talent Management priority project will enable us to take this forward.

Monitoring our performance is essential if we are to ensure that we are meeting the needs of our staff:

- Monitoring the results of the biannual Staff Survey in our Quarterly Disabled Vox Pop network will help us to determine better outcomes for disabled staff.
- We continue to report annually on the WDES (Workforce Disability Equality Standard), a set of ten specific measures, which will enable us to compare the experiences of disabled and non-disabled staff. Year on year comparison enables us to demonstrate progress or the need for improvement in regards to disability equality.
- Equality Impact Assessments 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. We have also reviewed our disciplinaries and Employee Relations Cases by disability and ethnicity with the HR team. We are currently reviewing our Sickness policy, to ensure that disability and mental health are fully included

All recruitment opportunities are advertised with two ticks for disability and managers are required to interview candidates that declare disabilities as long as they meet the minimum criteria, regardless of number of applicants. Our Bullying and Harassment policy and Diversity and Inclusion policies affirm our zero tolerance approach to any discrimination including with regards to Disability. The refresh of our Recruitment and Selection policy will also include this.

Diversity and inclusion policies

Inclusive Policies is a Priority Project for Inclusion, this will include a refreshed Equality Diversity and Inclusion Policy and we are working towards finalising a set of 'Inclusion' principles that need to be followed by policy authors. This would include consideration of data collection by single equality strand and referral to best inclusion practice. We will also be creating a guide (currently in draft stages) on 'How to write an inclusive policy'. All new and refreshed policies are currently advised to have an Equality Impact Assessment completed and attached to the policy. Although this assessment is being used throughout the trust, it will be included in the 'Inclusion principles for policies'.

The relaunch of the Trust Equality Standard, a new framework and toolkit, will be embedded within our new divisional structure, bringing the inclusion agenda and data sets to a more local level for increased local focus and support. This Standard will include a set of measures; bronze, silver and gold, with the ambition of all divisions to have achieved 'gold' level standard by 2023/24. We will be shortly launching mandatory annual training on diversity and inclusion which will be case study focused, built on staff stories.

We are progressing key elements of this strategy through five Priority People Projects that were launched in year, namely; Policy Review, Diverse Panels, Reverse Mentoring, Talent Management and Service User Experience. Our Vox Pop staff networks (Black Asian and Minority Ethnic, LGBTQ+ and Disability) continue to grow and be a vibrant source of inclusion and diversity innovation. Now, with a growing number of members, network co-chairs and the launch of our Spiritual and Allies network, we want these groups to continue to thrive but to give more to our communities.

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 2020 the JCNC has convened on eight occasions; April 2020, May 2020, July 2020, September 2020, December 2020, January 2021, February 2021 and March 2021.

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 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.

During the pandemic we issued over 300 email bulletins to staff to keep them informed and updated on the evolving and changing situation. We also held fortnightly Zoom sessions for staff to ask questions to our Executive colleagues and clinical experts.

We have also grown the use of our social media platforms with increasing numbers of staff following the Trust on our different social media 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 practice 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 health and safety. This has further been strengthened through partnership working and sharing good practice with neighbouring Trusts, staff and patients.

The Health and Safety Team have carried out workplace support visits at our sites when requested to enhance Health and Safety and support our staff. The aim of the workplace support visits is to prevent work related accidents and ill health by identifying hazards and risk and ensuring compliance. The support visits check whether existing preventative and protective control measures are working effectively. The visits also allow further/other recommendations for improving the sites and management of Health and Safety.

The Health and Safety Forum (Committee) continues to be held quarterly. Progressing objectives and action plans, oversight of health and safety risks and incident statistics are standing agenda items. Reports from subject matter experts including Estates and Facilities are included.

The team also continues to provide online support when required. 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.

Work has also been underway during the year in preparation for the implementation of the Government Functional Standard for Counter Fraud, which will replace the NHS Standards for Providers from 1 April 2021. The Trust's self-assessed rating covering the period 2020/21 is Green.

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. Proactive work this year has included reviewing procedures in place to mitigate against the increased fraud risks that have emerged from the pandemic.

All work undertaken by TIAA is overseen by our Finance Director and the Audit, Risk & Assurance Committee.

Trade Union activity time

Relevant union officials:

Number of employees who were relevant union officials during this period	Full time equivalent employee number
12	8.9

Percentage of time spent on facility time:

Percentage of time	Number of employees
0%	5
1–50%	4
51–99%	0
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
£25,554.85	£278,213,000	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
1,189	389	32.72%

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 and conditions of employment
- negotiation and development of HR practices/ policies
- undertaking job grading/ evaluation
- attending to matters of discipline and 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

Through this very challenging year we have remained committed and have been as ever reliant on effective staff engagement to overcome the challenges posed by the pandemic, in co-production and close dialogue with our staff. Our staff engagement approach continues to be typified by key strands of involvement:

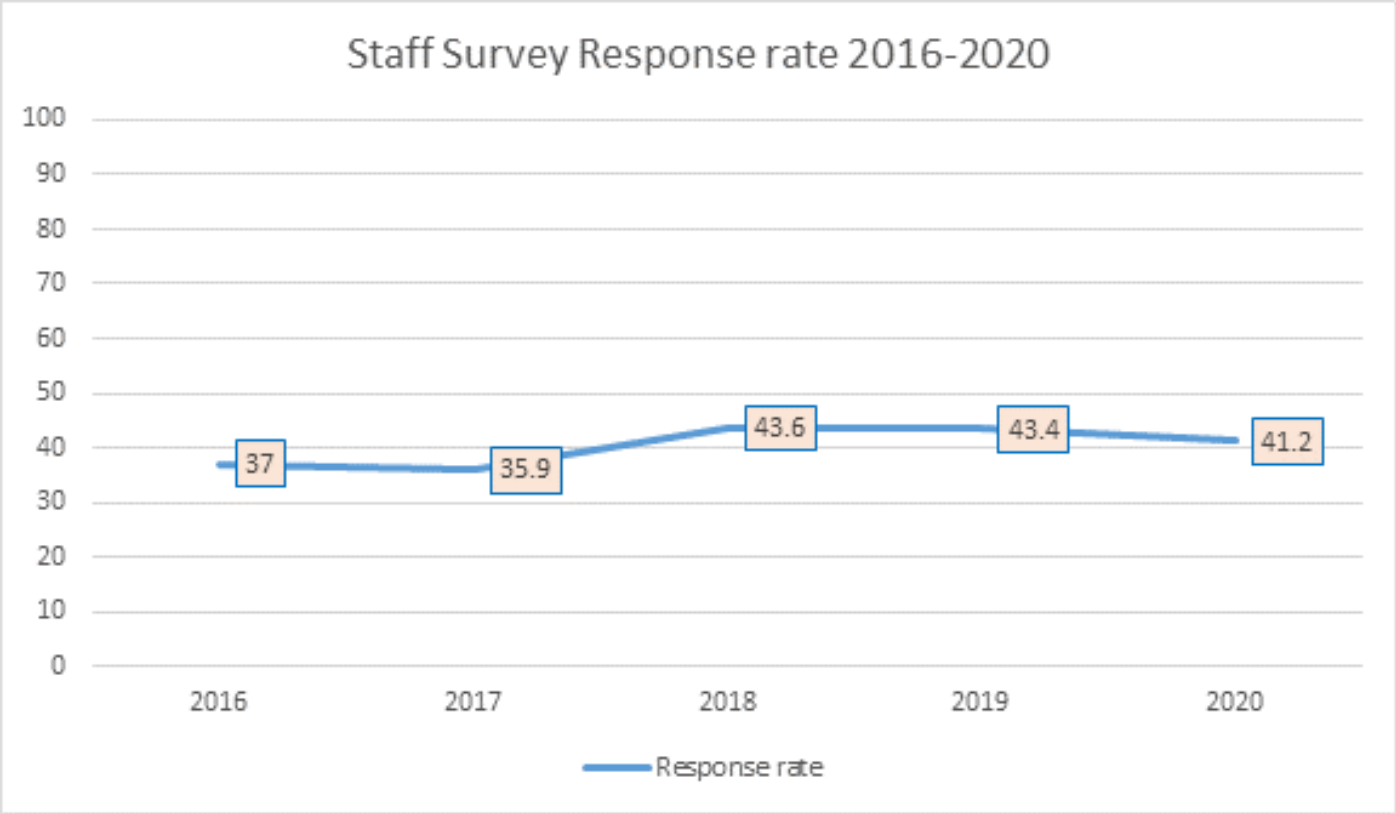
- We continue to further develop these in a culture of collective responsibility – of co-production – where it is everyone's business to ensure we create the services we want to be proud of. Through Quality Improvement approaches we enable staff to design outstanding services with the people that use them and their carers. This also requires us to co-create a working environment supporting a transparent 'just and learning' culture.
- We emphasise supporting people to make good decisions through coaching and mentoring, in providing internal consultancy support and introducing appreciative inquiry techniques to promote positive thinking and raise morale and pride.
- We continue to co-create systems and processes that attract, retain and develop a healthy workforce that will make Southern Health the best employer in the NHS.
- We will also ensure our people work in an environment they can develop and fulfil their aspirations; where there are clear career and development opportunities for them to flourish in their chosen field
- A priority in this challenging pandemic year has been our relentless focus on staff health, safety and well-being, creating safe spaces and working environments; where we can talk freely about mental health issues without fear or stigma, and where people with lived experience of using the full range of our services are embraced within the sphere of the Trust's work.
- We are working to create a culture where compassionate leadership is seen as everyone's business regardless of where and at what grade you 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 and where our workforce is representative of the diverse communities that we serve.

How we measure staff engagement?

We use the annual Staff Survey and mid-term Cultural Insights to measure engagement at Trust, Division, Care Group, Team and Single Equality Strand levels bi-annually. This data led approach to engagement enables us to target cultural support to areas most in need and learn from areas of high engagement and those on upward trajectories. Despite the pandemic requiring us to pause and create different remote ways of delivering cultural interventions, 65 teams benefitted from this data led approach in the last 12 months.

OUR 2020 NHS STAFF SURVEY RESULTS

The 2020 Staff Survey saw 2,537 (41.2%) staff respond compared to 2,520 (43.4%) in 2019. In recognition of the unprecedented pressures on staff this year, promotion of the survey was scaled back to ensure a focus on clinical care. Limited promotion however was encouraged through weekly email or paper reminders to individual staff members from Quality Health (supplier of the survey), weekly Staff Bulletin reminders, weekly updates on divisional response rates to divisional directors, and individual team managers.



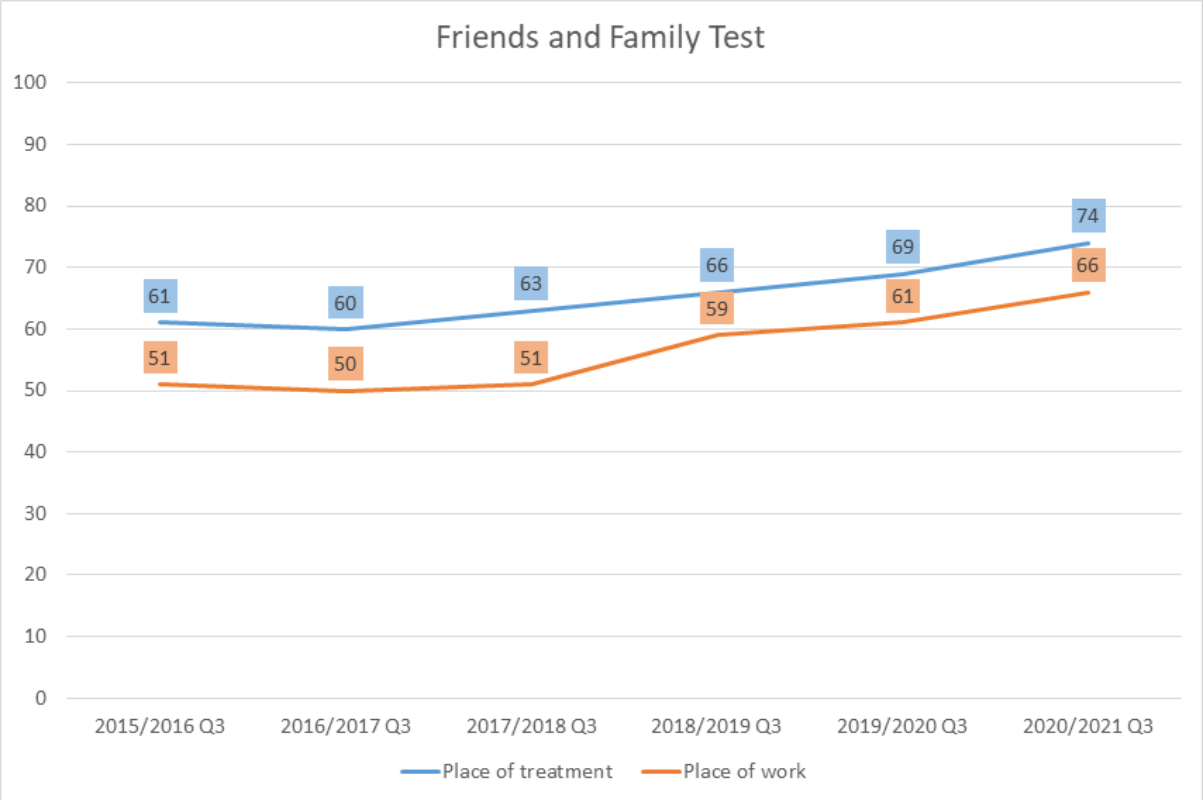
The majority of the scores for the National NHS 2020 Staff Survey were broadly in line with our sector's benchmark average scores, for similar organisations surveyed by Quality Health, with one theme 'Safe Environment – Violence' scoring significantly favourably.

When comparing at question level, our performance against the sector reveals 12 of 78 questions where the Trust is significantly better and 12 where the Trust is significantly worse. The better performing scores are particularly clustered around staff showing approval for the support and action of their immediate managers and reduced physical violence within our working environments.

Looking at year-on-year comparison within our own trust since the 2019 survey, most scores have also remained fairly stable. There have been 11 questions where the Trust showed significant improvement and 7 questions where the Trust reported a significant decline. Improvements are particularly focused around improved resources to do the job and greater advocacy from our staff towards their positive experience of belonging to our organisation.

More detailed information on the reports can be found at:
https://www.nhsstaffsurveyresults.com/homepage/benchmark-directorate-reports-2020/

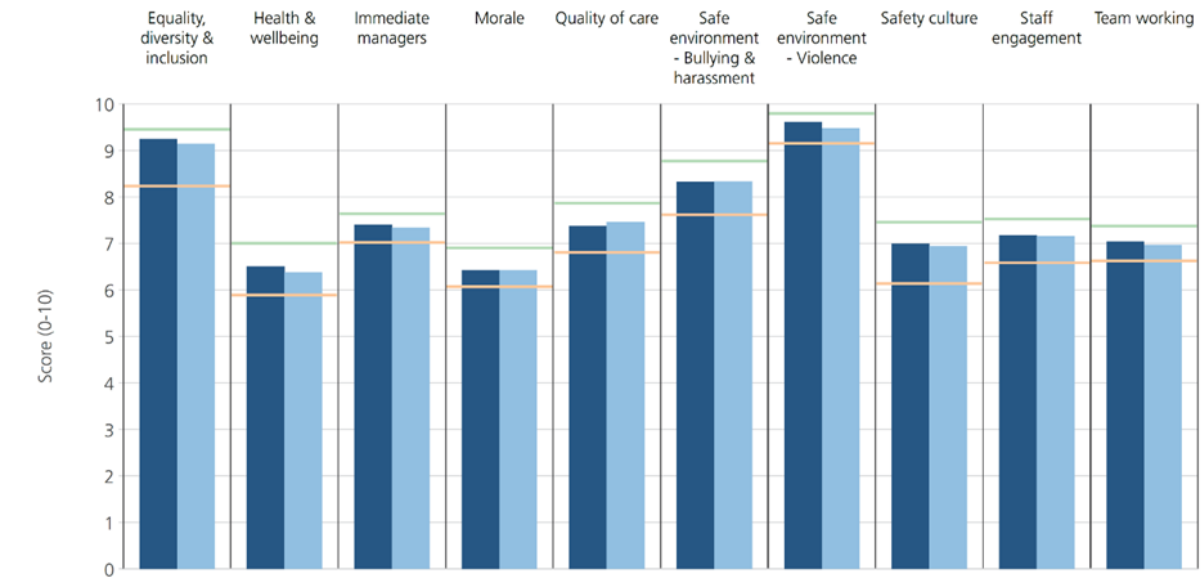
The Friends and Family Test, which has been on an upward trajectory since 2017, has shown both a 5% uplift in recommending Southern Health as a Place for Treatment and as a Place to Work.



The graph above shows the Friends and Family Test scores from 2015 – 2020

Indicator scores

The below graphs show the indicator score for the Trust for each of the 10 indicators in the staff survey report. We scored significantly better than the sector in Theme 7 Safe Environment – Violence. There are no significantly worse themes than the sector average. There are no significant differences between our theme scores between 2019 and 2020.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	9.2	6.5	7.4	6.4	7.4	8.3	9.6	7.0	7.2	7.0
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	2,523	2,533	2,526	2,527	2,132	2,518	2,524	2,530	2,534	2,483

Score for the Trust against each of the 10 themes

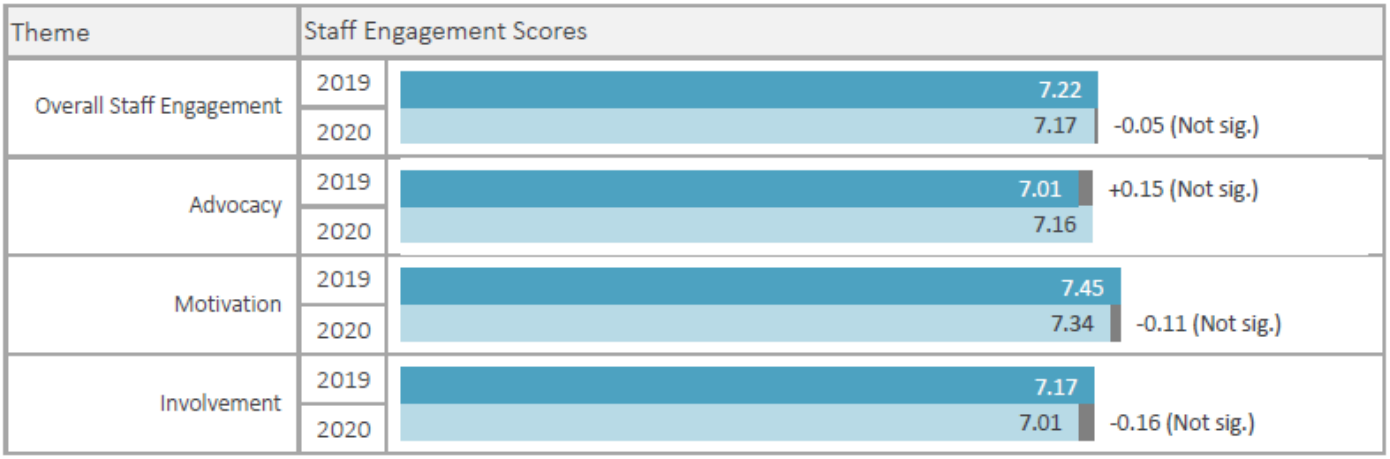
The tables and chart below show scores for each of the staff survey themes against our benchmark group for 2018, 2019 and 2020. They demonstrate that currently our staff engagement and cultural performance is comparable to sector norms, with us aspiring to improve this position in line with our People and Organisational Development Strategy 2019-2024.

	2020		2019		2018	
	Trust	**Benchmarking group**	**Trust**	**Benchmarking group**	**Trust**	**Benchmarking group**
Equality, diversity and inclusion	9.25	9.17	9.12	9.12	9.2	9.2
Health and wellbeing	6.51	6.47	6.32	6.21	6.2	6.1
Immediate managers	7.40	7.37	7.44	7.32	7.3	7.2
Morale	6.42	6.50	6.39	6.31	6.2	6.2
Quality of appraisal*	-	-	5.62	5.64	5.6	5.5
Quality of care	7.40	7.51	7.38	7.44	7.2	7.4
Safe environment – bullying and harassment	8.32	8.35	8.23	8.26	8.1	8.2
Safe environment – violence	9.61	9.51	9.52	9.47	9.5	9.5
Safety culture	7.0	6.98	6.92	6.84	6.8	6.8
Staff engagement	7.17	7.20	7.22	7.09	7.1	7.0
Team working	7.04	7.00	-	-	-	-

* No data available for 2020 on the Quality of Appraisal. A shortened version of an appraisal was carried out, due to the COVID-19 pandemic and limited time.

Action plans to address areas of concerns

In terms of our engagement score, our Trust has declined by -0.05 overall in our benchmarking sector, comprising of 26 Mental Health, Learning Disability and Community organisations this year. Whilst this is 'not significant' in itself, it means we now rank 17th. The graph below shows the themes that comprise overall staff engagement and the percentage difference between 2019 and 2020.



With this in mind, the Staff Survey 2020 action plan focuses on continuing improvements around engagement, bullying and harassment, MSK, work related stress and staff feeling valued.

Also we are keen to perform an appreciative enquiry about why 66% of staff are recommending us as a place to work and why we are experiencing an 8% uplift in positive action on health and wellbeing.

Our 7 key actions are:

- Engage fully with all Southern Health employees to design and embed new ways of working from our learning during the pandemic.
- Introduce best practice guidance on valuing our staff; ensuring we fully appreciate and recognise everyone's contribution. This guidance will be co-produced with staff.
- Strengthen our Quality Improvement offer to ensure we enable all staff the opportunity to initiate and get involved in change.
- Continue to embed our Zero Tolerance Anti-Bullying and Anti-Harassment campaign across Southern Health.
- Encourage staff to take up offers contained in the regional HIOW wellbeing hub.
- Ascertain why MSK problems are increasing within certain work settings looking to improve preventative practice in these areas.
- Perform further analysis to better understand why our staff are increasingly recommending us as a place to work and why staff consider us to be taking positive action towards their health and wellbeing.

The Staff Survey 2020 data was added to our reporting system, Tableau at Trust, Divisional, Care Group and Single Equality Strand (BAME, disability, gender and sexuality) during March 2021. This helps us monitor progress and have conversations with teams about the continuous improvement of their respective cultures. Some teams now have six data sets dating back to 2017 to show their individual cultural journey. Understanding the data enables appreciation of and further learning from those teams on an upward trajectory and enables targeted, evidence based cultural interventions for those teams that are most in need of cultural support.

Our milestones relating to staff survey improvement are detailed in our People and Organisational Development strategy 2019 to 2024. They include:

- An increased sense of staff belonging demonstrated by achieving 70% staff Friends and Family Test score for place of 'Employment' and 'Care' by 2022/23.
- Our Cultural Insights Staff Engagement score to rise by 1.5% per annum until 2023/24 to a score of 75%. By 2021/22 no more than 5% of teams to have an engagement score less than 60%, with no team to be under 60% by 2023/24.
- Our Friends and Family Test, Cultural Insights and Staff Survey response rates to improve by 5% 'per annum' from 2019 baselines up to 2023/24.
- Our NHS Staff Survey score for staff engagement to be above benchmark comparator and amongst top 3 in sector by 2023/24.

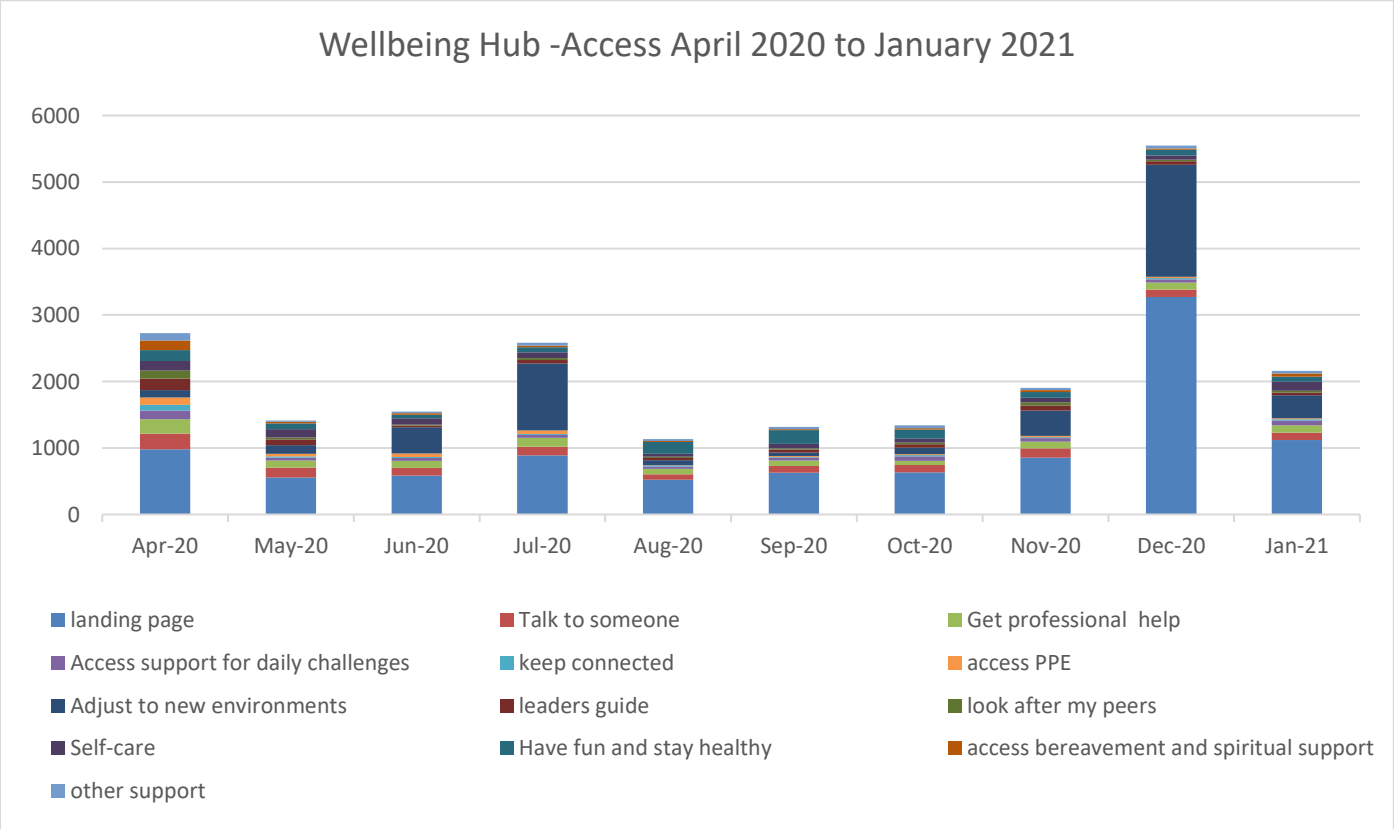
The progress against these milestones, and the staff survey action plan, will be monitored at our Workforce and Organisational Development Committee. In addition to these milestones during 2021/22 we are moving toward quarterly measurements of culture as opposed to bi-annual.

Supporting staff health and wellbeing

Wellbeing Hub

Health and Wellbeing has always been an important focus within the Trust, however since the beginning of the pandemic in March 2020, its prominence has grown considerably.

In response to the pandemic, the Trust wellbeing hub was created within two weeks to ensure staff had a single point of access for the entire Trust Wellbeing offer. Information and guidelines continue to be curated regularly and uploaded onto the Hub, ensuring that staff have access to the latest tools and support. The Hub continues to be popular amongst staff, with an average of 2,166 visits each month:



Our most popular pages have been:

- Talk to someone (this includes services like Listening Ear)
- Get professional psychological support (includes services such as italk, silvercloud and CISM)
- Adjust to new environments (includes our Wellbeing Assessment)

As part of our wellbeing hub offer, we have launched our Wellbeing Webinars which are open to all staff and are consistently well attended. So far, we have run webinars on the following topics: supporting the wellbeing of remote teams, digital fatigue, burnout, spirituality and wellbeing, critical incident stress management, agile working and reducing musculoskeletal disorders. Our decisions around topics are made from data gathered from staff, whether this is soft intelligence provided by colleagues or from one of our wellbeing surveys from summer 2020.

Wellbeing Assessment

Acknowledging that evidence was telling us that age, gender, and ethnicity are factors which can put people at higher risk from COVID-19, we developed and launched our Wellbeing Assessment in April 2020. The risk assessment was endorsed by the Trust Executive, Staff Side (Union representatives) and members of our Vox Pop community who all assisted in co-production.

The assessment enables colleagues to consider age, health status, gender and ethnicity in decision making, to help us keep our staff as safe as possible.

Starting off as a paper assessment, in Quarter 3 we launched an e-learning and e-assessment module on our training system. This includes:

- a section of four videos
  a. describing the well-being assessment
  b. the science data informing it
  c. the well-being offer in support
  d. advice of how to best conduct the assessment conversation.
- a short assessment – one question per video to ensure people understand the risks linked to wellbeing.
- a section to log assessment data and the associated actions agreed with the manager on a dropdown menu. Multi selections will be possible and most importantly, this data will not be open access.

Keeping up to date with government advice and guidelines, we are now on Version 9 of the assessment. Version 8 of the assessment had a 100% completion rate by BAME staff and 95% overall, version 9 had an 89.3% overall completion rate with 97.7% of BAME staff completing the assessment.

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. 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 50, 60 and 63 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 40-49, 64 and 79 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 61-62 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 49 of the Annual Report.
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 40-49 of the Annual Report.

Provision	Requirement	Reference in Annual Report/ response
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 78-79 of the Annual Report. Appointment Committee – This information is set out on page 64 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 on page 60 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 50 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 50 of the Annual Report.
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 page 72 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 107-117 of the Annual Report.

Provision	Requirement	Reference in Annual Report/ response
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 page 51 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 51-52 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
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 60 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 59 and 63 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 58-59 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 licence.

Segmentation

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

This segmentation is the Foundation Trust's position as at 31 March 2021. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

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:

Ron Shields, Chief Executive
10 June 2021

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 2021 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 Team 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; during 2020/21 we continued to strengthen the correlation between the operational risks on the risk register and the Trust's strategic risks and recognise we have more to do for this.

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.

The risk and control 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 and support is offered to staff, with appropriate training 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 last year.

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; these strategic risks describe the principal risks to the delivery of the strategic priorities within the Trust strategy. We have strengthened the alignment of operational risks to the strategic risks to ensure that there is a clear process whereby the Board is sighted on the breadth of the risk portfolio, with particular scrutiny on those risks outside risk appetite reported to designated Board Committees.

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 proactive management and eventual closure of identified risks. During 2020/21, we have increased the focus of operational risk reports to ensure that there is clear identification of those risks outside risk appetite, that risks where the identified target score has not been met are clearly highlighted, and that adequacy of actions is flagged for review.

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:

Strategic Priority	Strategic Risk
Improve health and wellbeing through outstanding services	There is a risk that we fail to improve health and wellbeing through outstanding services
Become the best employer	There is a risk that we fail to become the best employer
Transform services through integration and sustainable partnerships	There is a risk that we fail to transform services through integration and sustainable partnerships
Improve value	There is a risk that we fail to improve value

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 were monitored initially via the COVID-19 Quality Assurance Committee, and have since been subsumed into standard reporting and oversight arrangements. The Board also received assurance in-year that the Trust had reviewed and self-assessed against the national Infection Prevention & Control Assurance Framework, and actions were implemented to address any identified risks.

In the most recent 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'.

During 2020/21 the Board commissioned the Good Governance Institute to support the Board in undertaking a review against the Well-led framework, to inform future plans around ongoing development of the Board. The review included an observation of Board and Committee meetings and interviews with Board members and other senior officers. The draft findings identified that the Trust had come along way and has a strong foundation on which to build and noted that the organisation was already aware of and engaging with the issues and observations made from the review. The Good Governance Institute made a series of recommendations to support the further development of Southern Health as a well-led organisation. At the centre of the recommendations is a commitment to ongoing board development. Recommendations arising from the review will be considered and actions taken forward in 2021/22.

The Trust undertakes a review of compliance with the conditions of the Foundation Trust licence formally on an annual basis; this is reviewed in detail by the Audit, Risk & Assurance Committee on behalf of the Board. On the basis of this review, the Board makes a self-certification against NHS foundation trust licence condition 4 (FT governance) confirming compliance with the condition as at the date of the statement and for the forthcoming year and also in relation to compliance with General licence condition 6 (G6) for the year most recently ended.

Our self-certification made in June 2020 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.

The Working in Partnership Committee monitors progress against the Experience, Involvement and Partnership Strategy and are currently involved in setting objectives for 2021-23. The group provides a quarterly report to the Patient Experience and Caring Group, which in turn reports to the Quality and Safety Committee.

We have increased the number of carers groups across the Trust, where we seek feedback about our services. Carers leads have been appointed in our services to ensure carers and families are fully supported.

Regular Patient Experience audits have now been established, including a carers survey. Our services are supported to ensure a prompt response to the findings of the audits.

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. Key stakeholders with which we work closely include partner NHS Trusts, commissioners, local authorities, regulators and third sector organisations. We work proactively to engage with local authority Overview and Scrutiny Committees around any service changes being planned.

The early elements of our People and Organisational Development Strategy “Becoming the Best Employer” have been delivered, with the refreshed strategy updated and agreed by Board in November 2019. It sets out our aspirations to become the best employer; to be inclusive; ensure staff satisfaction; reduce turnover and vacancies and develop people with the right skills and attributes to deliver great services. All of these aspirations have a Board agreed measure of success and associated work programmes detailed in the strategy. The implementation of our People and Organisational Development Strategy has provided continued improvement in areas such as staff satisfaction, reduced turnover and vacancies.

Our People and Organisational Development Strategy is fundamentally designed to enable the delivery of the wider Trust aspirations and strategy in a way that is consistent with our values and is aligned to the NHS People Plan. It is critical to the delivery of good quality and safe services in numerous ways, not least having the right people with the right skills in the right place at the right time. To support this a process for 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.

Delivery, in part, also relates to having the effective, competency based planning approaches. These are developed with the services and aligned to the wider Trust strategy to deliver the identified operational plans. They detail both traditional and some new roles that will enable the Trust to continue to expand the range of services for our communities and citizens in line with identified needs. This is supported by the appropriate professional and performance governance frameworks to enable and monitor safety and effectiveness.

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 the Executive management.

The Trust has adopted the recommendations from 'Developing Workforce Safeguards' publication. In response to the COVID-19 pandemic, we took action to pause some areas of routine work within the Trust in order to redeploy staff to areas of higher need. This resulted in a very different skill mix in our inpatient units to that which would usually be planned. Training and local inductions were in place to mitigate the risk and mentorship support was also implemented.

During the second wave of the pandemic, we set up daily Trust-wide staffing panels. This enabled us to transfer resources across divisions to ensure inpatient units were safely staffed.

During 2020/21, regular reports on safer staffing were completed and presented to the Quality & Safety Committee and a six-monthly report made to the Board in November 2020. Due to the impact of the pandemic, we did not complete any acuity and dependency work during 2020, but this is planned to restart in 2021. We will also be increasing the frequency with which reports are provided to Board members on safer staffing.

We had planned to 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 during 2020/21; this will be carried forward to 2021/22.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. The Care Quality Commission last undertook an inspection of the Trust in 2019; the rating applied to the Trust, in January 2020 improved from "Requires Improvement" to "Good".

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.

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 Foundation Trust invested £14.6m (including donated / grant funded assets of £0.3m) in a range of capital projects in 2020/21. This included:

- £2.2m for the final year of the major secure services development comprising a new learning disabilities residential unit (which was completed late summer of 2020) and a low-secure adolescent unit (Austen House) which was opened in 2019
- £4m (of the £9.5m programme) for the eradication of mental health dormitories which has attracted national funding; and
- £0.9m for the replacement of the MRI scanner at Lymington Hospital with installation by July 2021.

The remainder of the general capital programme of £8.1m covered projects for reducing ligature risks, improving health and safety, planned maintenance, new medical devices and investment in digital / information technology.

During the year the Trust delivered savings of £18m (4.7% of the cost base) of which £8.1m were non-recurrent. The initiatives comprise a reduction in the use of mental health beds not within our bed stock, workforce redesign, procurement and reduction of corporate overheads.

Our long term strategic objectives are translated into specific statements of success, annual actions and measures of success. These are given clearly defined metrics and targets that are monitored at Trust, divisional and team level. Regulatory and commissioner defined targets are aligned to the appropriate strategic priorities and actions. 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 priorities.

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 high 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 Group which allows for Executive Director oversight on performance against the four strategic priorities.

Whilst a number of Divisional and Trust level committees were suspended due to the Covid-19 pandemic, monitoring of key performance indicators continued and reports were produced for review and oversight by committee members. Regular and frequent update meetings were held via videoconference between the Committee Chair and Executive Leads.

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.

The Internal Audit function adopts 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 will publish its Data Security and Protection Toolkit for 2020/21 at the end of June and is aiming for "exceeded standards met" as per previous years.

There were two potential Level 2 confidentiality breaches in the financial year 2020/21, 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 Data Security and Protection 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. As at 31/03/2021 there was one open report to the Information Commissioner's Officer under investigation; this was subsequently closed in late April 2021.

There have been six "concerns" raised to the Trust by the Information Commissioner's Office in the period, four relating to the processing of subject access requests by the Foundation Trust and two relating to potential breaches of confidential information. These have been fully 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

The Director of Strategy & Infrastructure Transformation, as Senior Information Responsible Officer for the Trust, is the accountable Director for data quality. Our Finance Director is the senior responsible officer for performance and works closely with our Performance team in order to monitor and hold divisional management to account with regard to metrics. Data quality forms an element of this role and is regularly discussed as part of the monthly performance monitoring cycles and is subject to regular review at board level through the Finance and Performance Committee and through Board reporting. Identified individuals within the Trust, including those in the areas of informatics, clinical coding, systems support and the Caldicott Guardian, have particular responsibility for data quality issues in those areas.

Every individual that is a registered user of a Trust System is responsible for ensuring the data quality of records when using the system. Responsibilities concerning data quality are explicitly stated in the job descriptions of all staff involved in the collection or processing of data that is input to relevant information systems. Line Managers are accountable for ensuring each individual within their Team is complying with Data Quality standards and where errors or breaches in protocol are identified these are addressed and rectified. Information relating to incidents occurring due to poor data quality or information governance breaches are available to all staff via the Trust's Business Intelligence tool, Tableau and discussed at the Information Governance Group.

The Trust Data Integrity Group is a virtual group of corporate partners and is used to ensure any hierarchy changes to Trust systems are assessed prior to implementation to ensure a consistent hierarchy is used across all Trust systems.

Every clinical and corporate division is required to have robust performance management processes in

place that ensure data quality is regularly reviewed and actions are taken to correct any errors or weaknesses in existing processes. Data Quality measures are included within every Business Unit Dashboard (Divisional Buddy) and an assessment of Data Quality. Good practice and areas of concern are raised and discussed in team and divisional performance meetings, highlighted in EPGs and at Trust level if relevant in regard to the performance of a specific metric or KPI.

The Trust has a Data Quality Policy and Framework in place. This is in place to ensure all data that is recorded is accurate and complies will all legal, statutory and recommended Information Governance standards. The policy is reviewed and maintained by the Trust Information Governance Group.

The Trust is adopting the national data quality assurance framework to deliver best practice in data quality.

There are a number of related policies and procedures in place to support the delivery of data quality and meet legislative requirements, these include Clinical Record Keeping Policy, Subject Access Requests and Disclosure of Personal Data Procedure, Information Lifecycle Policy (Records Management), Information Governance Policy, Data Protection & Confidentiality Policy, Policy for the Management of Personal Information, Clinical Audit Policy

Our approach to data management and presentation via Tableau Business Intelligence software takes a patient to board approach. This builds all metrics once at an individual patient level using defined business rules. This can then be grouped to different levels of our organisational hierarchy to monitor compliance as needed.

The advantage of this approach is consistency and auditability of the data presented, whereby individual patients driving a specified performance can be easily identified.

Data quality and auditing is led by specific individuals in our performance team. Their role is to monitor specific data quality and performance metrics within our Business Intelligence tool Tableau and escalate to divisional heads of nursing and other operational managers who have ultimate responsibility for compliance. In addition to monitoring data quality and compliance via Tableau, the performance team complete audits on key measures. This involves a more in depth look to understand the quality and timeliness of recording as opposed to whether or not a particular data item is present.

There are a number of processes for the monitoring of data quality compliance, including, but not limited to:

- Monthly data quality audits of two indicators a month (across regulatory, commissioner and trust internal indicators)
- Audit of a minimum of 10 clinical records bi-monthly to assess clinical coding compliance undertaken with clinical coding partner; and
- Annual external audit of 100 clinical records

External Benchmarking is currently included within our reports where this has been investigated and is available. This includes Patient Experience and Integrated Performance Report metrics such as Care Programme Approach reviews. Whilst this relates to performance in the first instance it can assist in highlighting data quality issues that may contribute to us being an outlier.

Validation of elective waiting times is completed in line with national referral to treatment standards requirements. This includes the continuous review of all relevant patient pathways, clock starts and stops, monitoring against national targets. Our booking teams, operational and clinical staff all work closely together to ensure patient choice, clinical need and patient safety requirements are met. During the Covid-19 pandemic we were required to suspend all but urgent and essential elective services as staff were redeployed to support essential service delivery. This inevitably led to delays in patient treatment. The Trust enacted restoration and recovery plans to ensure any delays were as short as possible.

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 and 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.

The Clinical Audit Programme for 2020/21 was suspended as part of the Trust's response to the COVID-19 pandemic. The majority of audits within the National Clinical Audit Programme were also suspended with those continuing being optional for Trusts to participate in. However, some local clinical audits were still undertaken during the year where teams had the capacity to do so. Contractual requirements to complete clinical audits was removed by commissioners during 2020/21; our commissioners held fortnightly meetings with us instead, to ensure that the quality of care delivered during the pandemic was maintained at the required level.

The Foundation Trust commissions a risk-based programme of assurance reviews from BDO, our internal auditors. Our Internal Audit Plan for 2020/21 was approved by the Audit, Risk & Assurance Committee, and seven audits were undertaken during the yearend. Based on the work undertaken in 2020/21 we received the following Head of Internal Audit Opinion:

"The role of internal audit is to provide an opinion to the Board, through the Audit Committee (AC), on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period. The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- An assessment of the range of individual opinions arising from risk based audit assignments contained within internal audit risk based plans that have been reported throughout the year.
- This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and
- Any reliance that is being placed upon third party assurances.

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:

- As at 31 March 2021, the Trust's pre-audited financial outturn is a £0.1m surplus, £3m favourable variance to the plan. There are technical adjustments for impairments which go into the accounts and once these are included the outturn is £2.6m deficit against the planned deficit of £6.1m. The position is better than plan mainly due to securing additional income.
- All audits concluded provided moderate or substantial assurance in the design of controls, including key audits such as key financial systems and data security and protection toolkit.
- We have closed all bar two prior year (2019/20) recommendations that have fallen due and management are proactive in discussing plans to address the risks identified in the 2020/21 audits. There has been some slippage in implementation dates experienced during the year, primarily due to the operational impact of Covid but the Audit Committee have been closely monitoring these."

During 2020/21 the Trust implemented business continuity arrangements in response to the COVID-19 pandemic. This included the establishment of an Incident Control Centre in line with the NHS Emergency Preparedness, Resilience and Response arrangements. Additionally, in response to the NHS England guidance "Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic", the Trust took action to reprioritise and refocus resources to ensure operational delivery could be maintained in key areas. This 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 Board also established a COVID-19 Quality Assurance Committee and a Clinical Ethics Forum to support our governance arrangements to remain robust and responsive during the year.

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

Performance targets

We have met all but two of the nationally mandated targets for the year. Performance against both the national Referral to treatment target and Diagnostics performance target were below target as a direct consequence of prioritisation of service delivery in response to the COVID-19 pandemic.

Stage 2 Independent Public Investigative Hearing

In February 2020, NHS England/Improvement published an independent report into the care of four patients who died whilst under the care of Trust services between 2012 and 2015, and the subsequent investigations and liaison with the patients' families. This report, authored by Nigel Pascoe QC, found significant failings in the Trust's response at the time, and recommended a public investigative process to determine the extent to which the Trust has improved in respect of key policy areas such as complaints handling, serious incident investigations (including learning from deaths) and engagement with families. A series of public hearings took place throughout March and April 2021, chaired by Nigel Pascoe QC, and a final report is due for publication in July 2021.

Once published, the Trust will respond fully to any recommendations arising from the report.

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 2020/21. Where control weaknesses have been identified, action has been taken or improvement plans are in place to address these issues.

Signed:

Ron Shields, Chief Executive

10 June 2021

APPENDIX A

SOUTHERN HEALTH NHS FOUNDATION TRUST 2020/2021 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 the rising cost of natural resources and the climate emergency. Demonstrating that we consider the social and environmental impact of our services 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 in our Green Plan.

'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 for reducing the carbon footprint of the NHS, in October 2020 NHS England published their "Delivering a Net Zero National Health Service" report, setting two clear and feasible targets for the NHS Net Zero commitment. Our Trust is therefore committed to reducing the emissions we control by 80% by 2028-2032 and becoming net zero by 2040. As well as reducing the emissions we can influence by 80% by 2036 to 2039 and becoming net zero for these emission by 2045.

Our Green Plan also reflects the need to support the transition to a circular economy, protect scarce natural resources, and 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. Alongside our Green Plan we are developing a Net Zero Pathway and Action Plan which will be published in 2021.

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, the SDAT score assessed ten different modules including corporate approach, asset management, travel, adaption, capital projects, green space, sustainable care models, our people, resource use and greenhouse gases, and will be setting further improvement targets. 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 (United Nations) 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.

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. This sustainability report has used the financial year to report all data throughout, covering the period 01 April to 31 March.

	2013	2014	2015	2016	2017	2018	2019	2020
Floor Space (m2)	151,000	135,571	109,940	98,532	102,209	108,633	108,036	109,338
Number of Staff	6,533	6,337	5,874	5,198	4,997	5,047	5,166	5,553

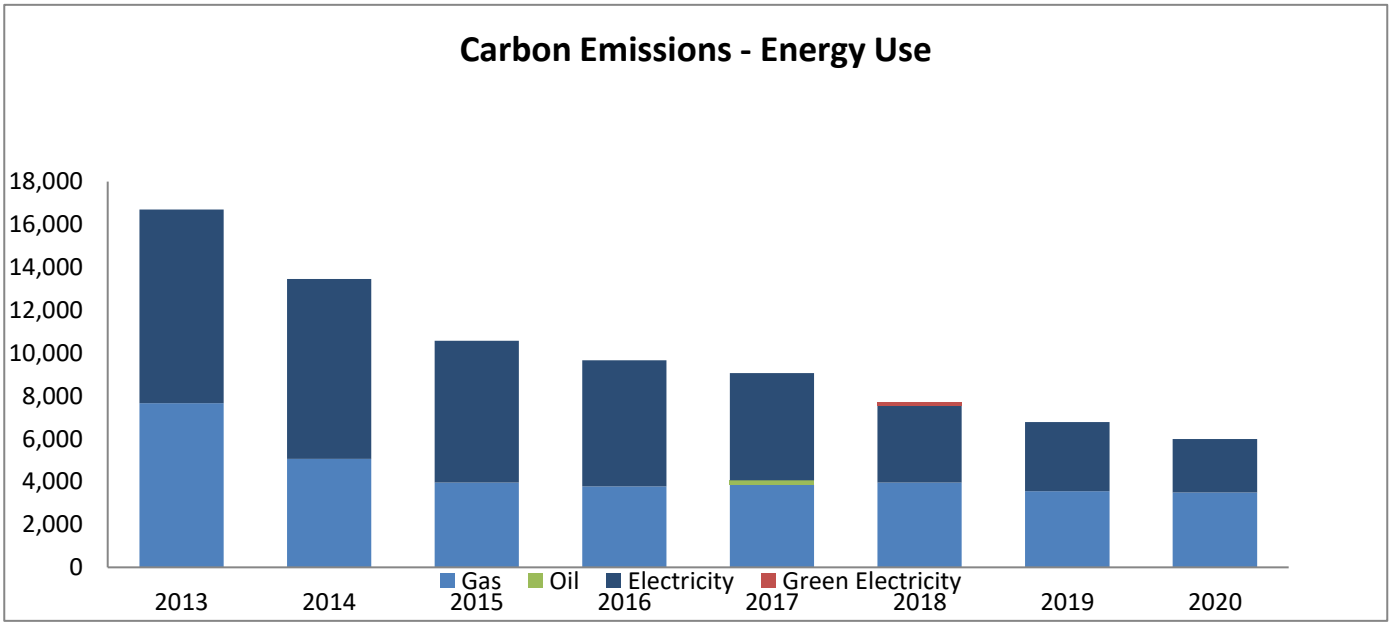
In 2020 NHS England outlined an ambition to create the first Net Zero Health Service. We support this ambition and are taking action across a range of areas:

Energy

The Trust spent £1,554,002 on energy in 2020, which is a 4% decrease on energy spend from the previous year. From 2013 to 2018 the Trust reduced energy consumption from 52,275,000 kWh to 25,463,161 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).

Based on latest carbon factors our energy consumption created 5957 tonnes of carbon dioxide emissions equivalent (tCO_2e), which is a 64% decrease from our 2013 baseline.



Carbon emissions – Energy use

Resource	Mode	2013	2014	2015	2016	2017	2018	2019	2020
Gas	kWh	36,138,815	24,141,146	18,902,558	18,091,956	18,146,945	18,855,970	17,120,033	16,672,458
	tCO_2e	7,666	5,065	3,956	3,781	3,786	3,951	3,557	3,464
Oil	kWh	0	0	0	0	658,789	0	0	0
	tCO_2e	0	0	0	0	215	0	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	8,651,961
	tCO_2e	9,035	8,392	6,618	5,878	5,006	3,606	3,217	2,493
Green Electricity	kWh	0	0	0	0	0	409,000	0	0
	tCO_2e	0	0	0	0	0	144	0	0
Total Energy CO_2e		16,702	13,457	10,574	9,659	9,068	7,701	6,774	5,957
Total Energy Spend		£2,143,334	£2,145,717	£1,647,769	£1,503,189	£1,548,064	£1,611,510	£1,628,711	£1,554,002

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 £3,504,609 on business travel in 2020, which is as 23% decrease from the previous year.

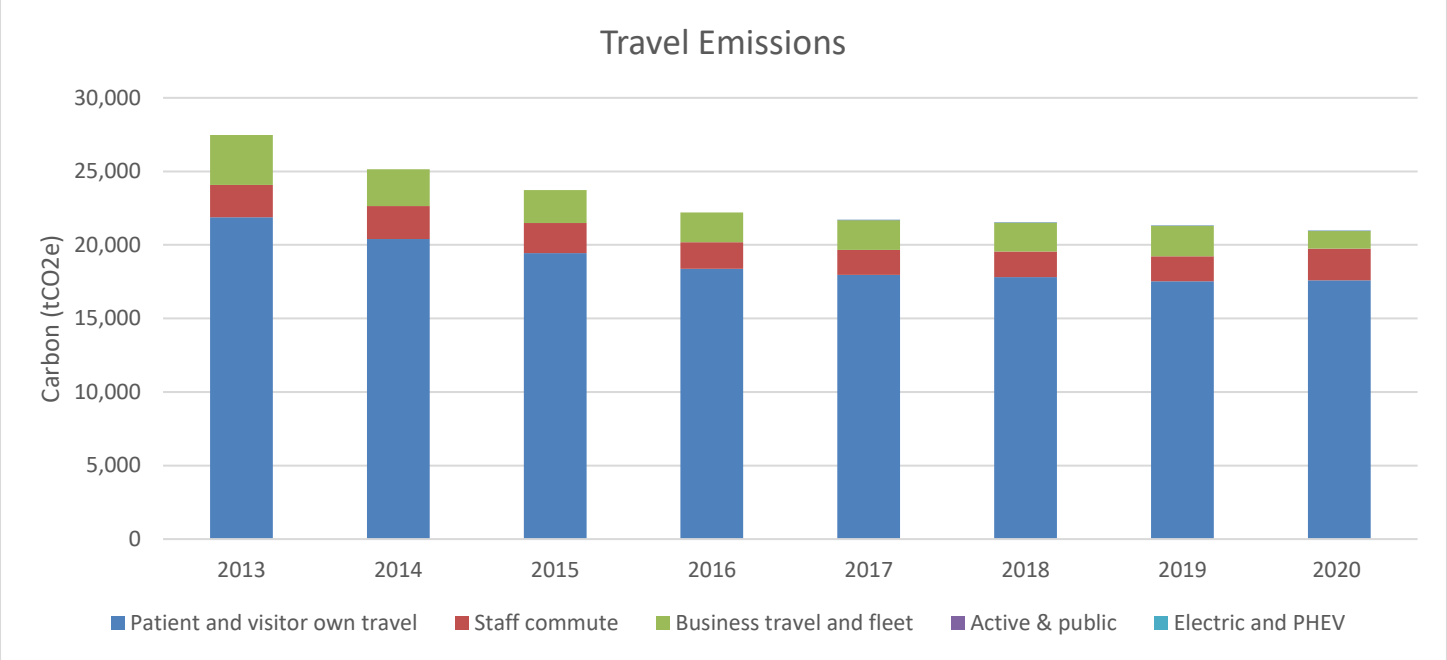
In previous years we have reported our patient and visitor own travel and staff commuting data, as seen below, however the patient and visitor travel emissions and those arising from staff commuting are estimated based on NHS travel survey data and assumptions. They are therefore indicative only. For example Patient and Visitor travel is calculated by using an average of 9.4miles and 3.7 patient and visitor journeys per patient contact.

With this in mind, data for 2020/21 will not reflect the impact of the COVID-19 pandemic on our patient and visitor travel as well as our staff commuting, and ultimately will not show the decrease that we would be expecting.

It is the intention that the Trust will undertake further work as part of our Net Zero Strategy development to identify the impact of the pandemic and these activities on emissions arising (CO_2e, but also emissions that contribute to poor air quality) and what measures need to be implemented to reduce these impacts.

Performance analysis of our travel (below these charts) will only reflect upon our business travel where we have more accurate data to report on.

Carbon emissions – Travel



Category	Mode	2013	2014	2015	2016	2017	2018	2019	2020
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	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	17,591,00
Staff commute	Miles	5,998,126	6,087,433	5,642,668	4,995,095	4,802,117	4,848,333	4,964,526	6,195,567
	tCO_2e	2,216.15	2,236.70	2,040.59	1,805.28	1,711.11	1,727.58	1,715.00	2149
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	3,381,235
	tCO_2e	3,387.86	2,493.43	2,237.10	2,037.19	2,014.36	1,967.18	2,057.00	1,215
Active & public transport	Miles	0	0	0	0	59,801	63,089	33,791	9,566
	tCO_2e	0.00	0.00	0.00	0.00	5.36	5.47	2.67	0.35
Electric and PHEV	Miles	0	0	0	0	15,570	10,796	16,218	33,980
	tCO_2e	0.00	0.00	0.00	0.00	1.77	1.23	1.85	5.3
Total Business Travel tCO_2e		3,388	2,493	2,237	2,037	2,021	1,974	2,062	1,220
Total Business Travel Spend		£ –	£ –	£6,034,526	£5,648,637	£4,697,854	£4,514,888	£4,575,535	£3,504,609

Our Trust travelled 3,381,235 miles on business in 2020, which is a 43% decrease on business travel from 2019. Our business travel created 1,215 tonnes of carbon dioxide emissions equivalent (tCO_2e).

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 £91,331, 687 on non-pay expenditure in 2020, which is a 6% increase on non-pay spend in 2019.

Our Trust non-pay procurement created 37,968 tonnes of carbon dioxide emissions equivalent (tCO_2e) in 2020, which is an 7% increase from 2019. Major sources of emissions from procurement arise from:

- building services
- staff and patient consulting services
- office equipment
- facilities management services
- pharmaceuticals.

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).

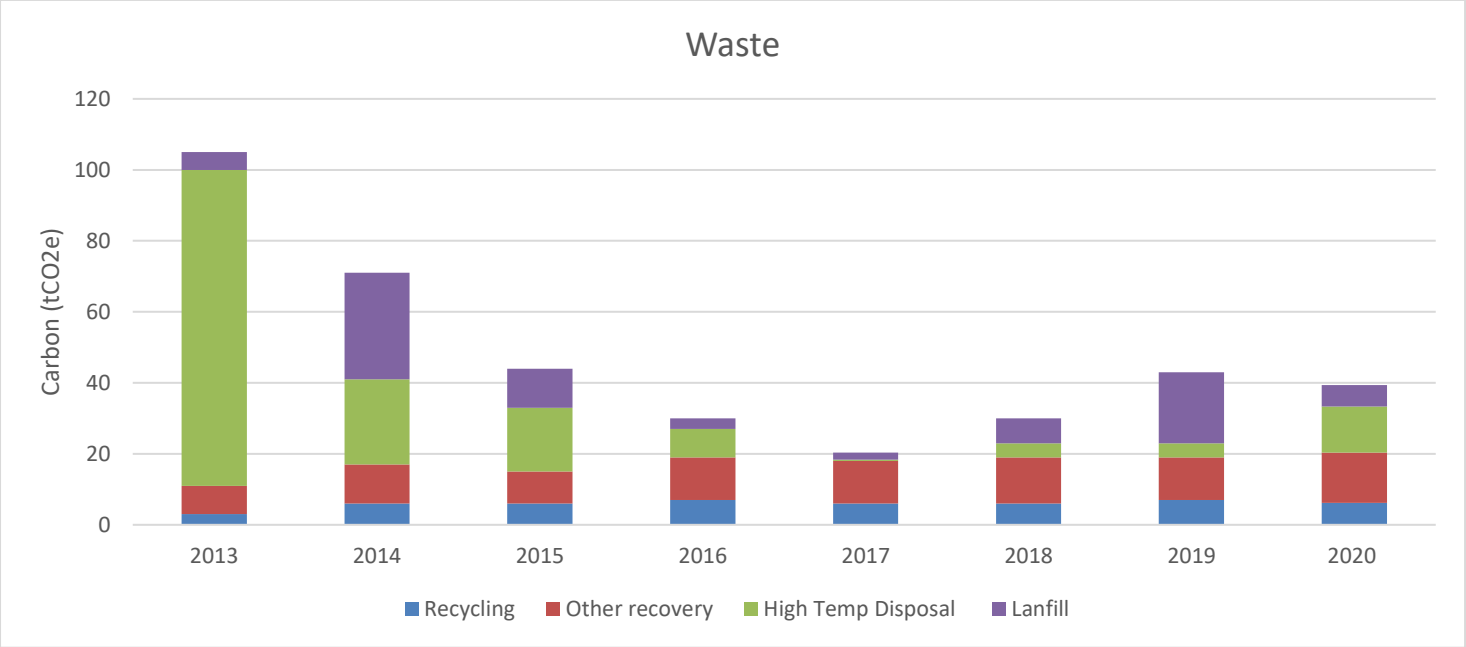
Our Sustainable Procurement Policy and Procedure ensures our procurement activities consider and seek to address the environmental and ethical impacts of the goods and services we purchase. Collectively as an organisation we recognise the contribution that commissioning, procurement and commercial can 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 £290,315 on waste management in 2020, which is a 9% increase on spend in 2019.



Waste		2013	2014	2015	2016	2017	2018	2019	2020
Recycling	tonnes	157	282	278	342	262	284	336	290
	tCO_2e	3	6	6	7	6	6	7	6
Other recovery	tonnes	362	508	458	567	556	584	552	666
	tCO_2e	8	11	9	12	12	13	12	14
High Temp disposal	tonnes	403	111	84	38	2	19	18	59
	tCO_2e	89	24	18	8	0.34	4	4	13
Landfill	tonnes	19	124	45	10	6	21	57	13
	tCO_2e	5	30	11	3	2	7	20	6
Total Waste (tonnes)		941	1025	865	958	826	907	963	1028
% Recycled or Re-used		17%	28%	32%	36%	32%	31%	35%	28%
Total Waste tCO_2e		104	71	44	31	20	30	43	39
Total Waste Spend		£229,965	£331,789	£350,214	£234,517	£296,407	£319,275	£264,303	£290,315

Our Trust produced 1028 tonnes of waste in 2020, which is a 6% increase from last year and a 9% increase from our 2013 baseline. Our waste created 39 tonnes of carbon dioxide emissions equivalent (tCO_2e),

which is an 8% decrease from last year, this is because more of our waste has been diverted from landfill. There has been a 62% decrease from our 2013 baseline.

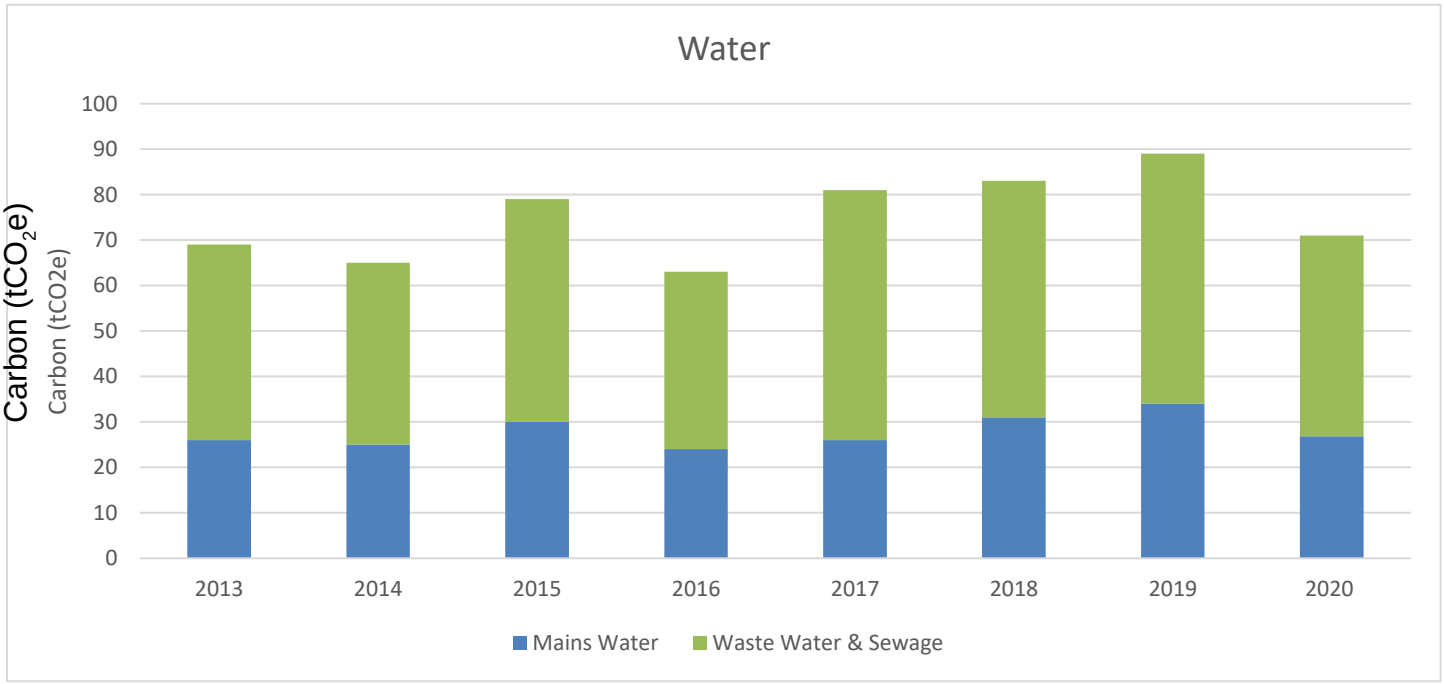
As part of our sustainable waste improvements, we are continuing to work with our Managed Waste Supplier to seek increased recycling rates and decrease our landfill and high temperature disposal.

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 £202,429 on water and sewage in 2020, which is a 17% decrease on water and sewage spend in 2019.

Carbon emissions – Water



Water		2013	2014	2015	2016	2017	2018	2019	2020
Mains Water	m^3	76,164	71,275	87,292	69,494	97,740	91,450	97,963	77,950
	tCO_2e	26	25	30	24	26	31	34	27
Waste Water & Sewage	m^3	60,931	57,020	69,834	55,595	60,194	73,232	78,370	62,360
	tCO_2e	43	40	49	39	55	52	55	44
Water & Sewage Spend		£ 302,942	£ 323,412	£ 325,612	£ 249,284	£ 256,350	£ 255,197	£245,167	£202,429

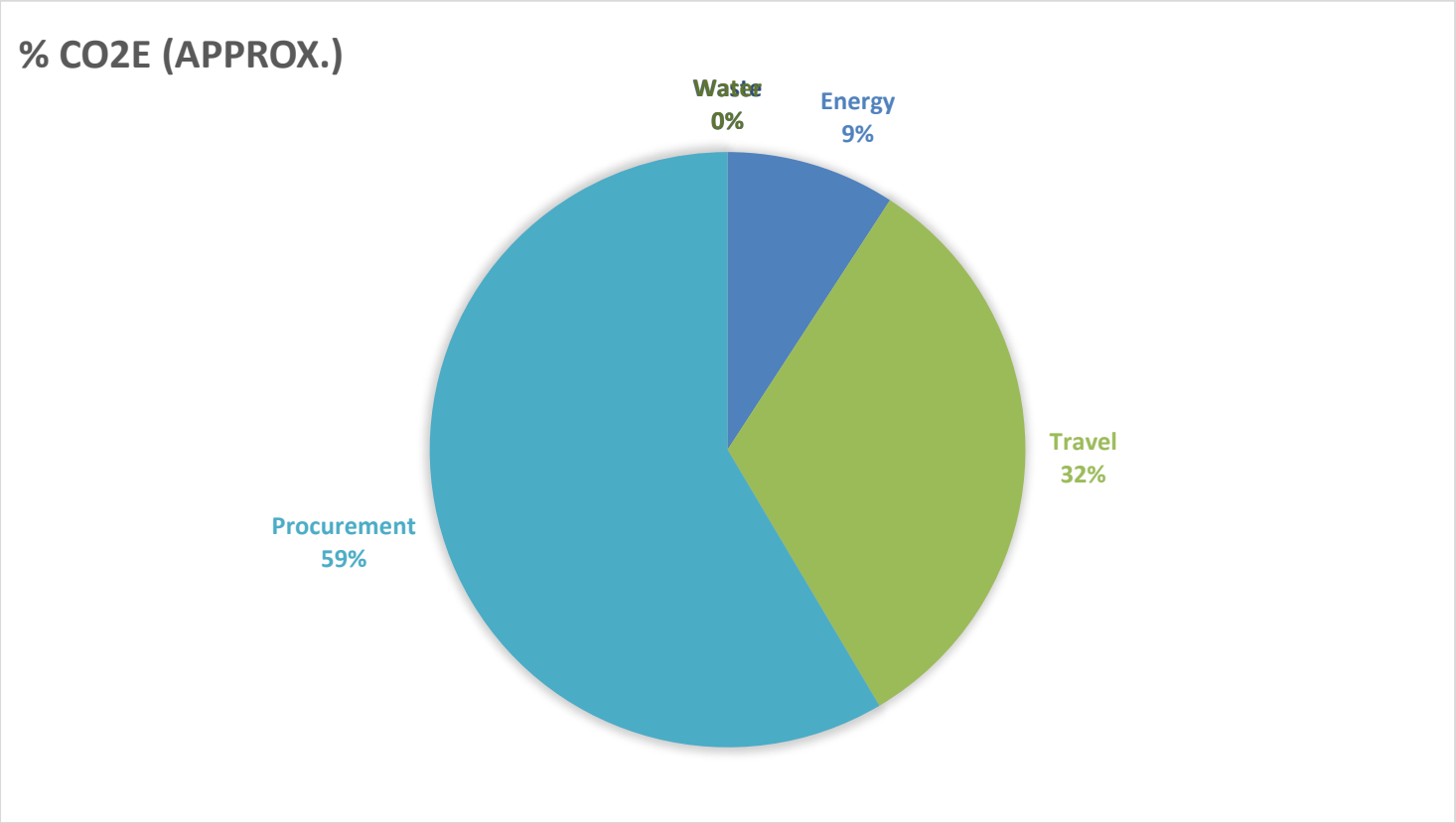
Our Trust used 77,950 cubic metres of water and created 62,360 cubic metres of wastewater and sewage in 2020. Our water usage, wastewater and sewage created 71 tonnes of carbon dioxide emissions equivalent (tCO_2e), which is an increase of 2.8% from our 2013 baseline.

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 (NHS+ Footprint)

Our 2020 activities resulted in an estimated total carbon footprint of 65,984 tonnes of carbon dioxide equivalent emissions (tCO_2e), the breakdown of which is shown below. This footprint includes non-core emissions, including patient and staff travel and procurement activities which are indicative and will not reflect the impact of the pandemic.

2020 Carbon footprint breakdown – Tonnes CO_2e



Category	Tonnes CO_2e	% CO_2e (approx.)
Energy	5957	9%
Travel	20,960	32%
Procurement	37,968	57.5%
Waste	1028	< 0.1%
Water	71	< 0.1%

CORE emissions (those which are directly controlled by the Trust – energy, waste, water and business travel) amount to a total of 6871 tonnes CO_2e.

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 Adaptation and Business Continuity Plans and these continue to be enhanced.

Biodiversity Action Plan

Working in partnership with local authorities, colleges, charities and the third sector, including New Forest National Park Authority, Minstead Trust and 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 the impact of the pandemic will have provided us with a picture that may not be that accurate as business returns to normal. 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 and the Trust is working towards this by developing a Net Zero Strategy which we aim to launch over the next year.

Our sustainability performance does not just reflect a focus on emissions. In 2019 we reassessed our overall sustainability status in accordance with the Sustainable Development Assessment Tool (SDAT) and were 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.

GLOSSARY

AHP	Allied Health Professional
Ally	An inclusion Ally is a colleague who supports all colleagues, and speaks up against complacency and injustice.
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
DESMOND	Diabetes Education and Self Management for Ongoing and Newly Diagnosed (www.diabetes.co.uk)
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
Section 136	A Section 136 place of safety is a normally residential accommodation provided health services where a person can receive mental health care and support. A Section 136 is normally given to someone who appears to be experiencing a mental health crisis in a public place and can be picked up by the police and taken to a place of safety to receive help.
SENSE	A discreet blood glucose monitor
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:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of its income and expenditure and cash flows for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

We have audited the financial statements, included within the Annual Report and Accounts 2020/21 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2021; 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 Equity for the year then ended; 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.

Conclusions relating to going concern

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

However, because not all future events or conditions can be predicted, this conclusion is not a guarantee as to the Trust's ability to continue as a going concern.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

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 2020/21 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 2021 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

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 required to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21 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.

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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

Based on our understanding of the Trust and industry, we identified that the principal risks of non-compliance with laws and regulations related to the Data Protection Act 2018, and we considered the extent to which non-compliance might have a material effect on the financial statements. We also considered those laws and regulations that have a direct impact on the financial statements such as the National Health Service Act 2006 and related legislation governing NHS Foundation Trusts. We evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls), and determined that the principal risks were related to the use of journals to manipulate financial performance and overstate costs to claim COVID-19 funding during the year as well as year-end top up funding. Audit procedures performed by the engagement team included:

- identifying and testing journal entries using a risk based targeting approach for unexpected account combinations;
- testing a sample of COVID-19 related expenditure to supporting documentation to verify that the Trust had correctly included expenditure that related to COVID-19 costs;
- testing a sample of accounts payable and accruals 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; and
- enquiring throughout the year with management, internal audit, local counter fraud specialist and those charged with governance to understand the relevant laws and regulations applicable to the Trust, including their assessment of fraud related risks and consideration of known or suspected instances of non-compliance with laws and regulations.

There are inherent limitations in the audit procedures described above. We are less likely to become aware of instances of non-compliance with laws and regulations that are not closely related to events and transactions reflected in the financial statements. Also, the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion.

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.

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

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

Under the Code of Audit Practice we are required to report, by exception, whether any significant weaknesses were identified during our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources, and to refer to any associated recommendations. As explained further in our Auditor's Annual Report, our work was performed in the context of the COVID-19 pandemic and resulting changes in both the operating and financing regimes for the NHS for the year.

We determined that there were no significant weaknesses to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if, in our opinion:

- the statement given by the directors on page 72, 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 51-52, 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 2020/21 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 of 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
15 June 2021

Southern Health NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Southern Health NHS Foundation Trust
Annual Accounts for the year ended 31 March 2021

Contents

Foreword to the accounts

Southern Health NHS Foundation Trust

These accounts, for the year ended 31 March 2021, 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 **Mr Ron Shields**
Job title **Chief Executive Officer**
Date **10.06.2020**

Southern Health NHS Foundation Trust
Annual Accounts for the year ended 31 March 2021
Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	340,078	312,044
Other operating income	4	43,180	25,304
Operating expenses	6	(380,717)	(335,058)
Operating surplus from continuing operations		**2,541**	**2,290**
Finance income	11	-	281
Finance expenses	12	(1,231)	(1,212)
PDC dividends payable	12.3	(4,491)	(4,733)
Net finance costs		**(5,722)**	**(5,664)**
Other gains/(losses)	13	609	21
Deficit for the year		**(2,572)**	**(3,353)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(2,233)	(6,613)
Revaluations	17	859	6,641
Total comprehensive expense for the period		**(3,946)**	**(3,325)**

Southern Health NHS Foundation Trust
Annual Accounts for the year ended 31 March 2021

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	2,391	3,314
Property, plant and equipment	15	204,576	202,276
Receivables	20	397	338
Total non-current assets		**207,364**	**205,928**
Current assets			
Inventories	19	57	85
Receivables	20	8,701	19,423
Non-current assets for sale	21	-	1,818
Cash and cash equivalents	22	46,752	13,281
Total current assets		**55,510**	**34,607**
Current liabilities			
Trade and other payables	23	(47,385)	(33,366)
Borrowings	25	(362)	(5,421)
Provisions	27	(1,577)	(453)
Other liabilities	24	(10,787)	(5,654)
Total current liabilities		**(60,111)**	**(44,894)**
Total assets less current liabilities		**202,763**	**195,641**
Non-current liabilities			
Borrowings	25	(14,928)	(15,290)
Provisions	27	(1,275)	(557)
Total non-current liabilities		**(16,203)**	**(15,847)**
Total assets employed		**186,560**	**179,794**
Financed by			
Public dividend capital		103,870	93,158
Revaluation reserve		54,177	55,551
Other reserves		(755)	(755)
Income and expenditure reserve		29,268	31,840
Total taxpayers' equity		**186,560**	**179,794**

The notes on pages A5 to A44 form part of these accounts.

Signed .....
Name Mr Ron Shields
Position Chief Executive Officer
Date 10.06.2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020	**93,158**	**55,551**	**(755)**	**31,840**	**179,794**
Deficit for the year	-	-	-	(2,572)	**(2,572)**
Impairments	-	(2,233)	-	-	**(2,233)**
Revaluations	-	859	-	-	**859**
Public dividend capital received	10,712	-	-	-	**10,712**
Taxpayers' and others' equity at 31 March 2021	**103,870**	**54,177**	**(755)**	**29,268**	**186,560**

Statement of Changes in 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	**89,292**	**55,523**	**(755)**	**35,193**	**179,253**
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**

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:

£4,438k for eradicating dormitory style wards at Parklands and Gosport War Memorial Hospitals
£300k for capital spend to support the Covid-19 Response
£5,000k of new PDC Dividend Capital to repay the DHSC interim loan received during 2019/20 in line with the national guidance
£974k to support several digital investment projects

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, in which case they are recognised in operating expenses.

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	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus		2,541	2,290
Non-cash income and expense:			
Depreciation and amortisation	6.1	9,032	8,452
Net impairments	7	2,797	(1,655)
Income recognised in respect of capital donations	4	(255)	(825)
Decrease in receivables and other assets *	20.1	10,777	432
Decrease / (Increase) in inventories	19	28	(4)
Increase in payables and other liabilities **	23.1 & 24	16,211	186
Increase / (decrease) in provisions	27.1	1,842	(1,693)
Net cash flows generated from operating activities		**42,973**	**7,183**
Cash flows from investing activities			
Interest received	11	-	281
Purchase of intangible assets	14.1	(848)	(922)
Purchase of property, plant and equipment	15.2	(10,703)	(17,440)
Sales of property, plant and equipment	21 & 13	2,427	21
Receipt of cash donations to purchase assets	4	255	825
Net cash flows used in investing activities		**(8,869)**	**(17,235)**
Cash flows from financing activities			
Public dividend capital received	SoCIE	10,712	3,866
Movement on loans from DHSC	25.2	(5,000)	5,000
Capital element of PFI, LIFT and other service concession payments	25.2	(418)	(400)
Interest on loans	25.2	(3)	-
Interest paid on finance lease liabilities	12.1	(4)	(4)
Interest paid on PFI, LIFT and other service concession obligations	12.1	(1,227)	(1,205)
PDC dividend paid	12.3	(4,693)	(4,329)
Net cash flows (used in) / from financing activities		**(633)**	**2,928**
Increase / (decrease) in cash and cash equivalents		**33,471**	**(7,124)**
Cash and cash equivalents at 1 April		**13,281**	**20,405**
Cash and cash equivalents at 31 March	22.1	**46,752**	**13,281**

* This balance excludes PDC dividend receivable per Note 20.1.

** This balance is adjusted for the change in capital creditors and excludes PDC Dividend payable within Payables Note 23.

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) 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.

Note 1.2 Going concern
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

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.

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 18.1 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 36. 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 Southern Health NHS Foundation Trust who employs the practice staff and underwrites 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 deemed this partnership immaterial in 2020/21 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 18.2.

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

2020/21

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

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

Comparative period (2019/20)

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

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

For 2020/21 and 2019/20

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and 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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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 the 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; and
- 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. Also, where new builds have been assessed as exempt from VAT, this is excluded from the valuation.

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 in so far as these terms are consistent with the agreed requirements of NHS Improvement and HM Treasury.

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 in 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 the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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.

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.

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 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 31 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	-	75
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.

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.

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. An intangible asset which is surplus with no plan to bring it back into use is valued 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.
Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful 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.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

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.

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 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.

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.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses at an amount equal to lifetime expected losses.

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 2021:
Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

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 27.2 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 28 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 28, 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 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 2021 or 31 March 2020 spot exchange rates. No exchange rate gains or losses are therefore recognised in the NHS Foundation Trust's deficit 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 incluided as normal 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 2020/21.

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 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2022, the 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 defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. 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 2022 for existing finance leases.

For leases commencing in 2022/23, 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.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

There are two other standards issued but not yet adopted.
IFRS 14 Regulatory Deferral Accounts - Not applicable to DHSC bodies
IFRS 17 Insurance Contracts - Early adoption is not permitted by FReM

Note 1.24 Sources of estimation uncertainty and critical judgements

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 2020/21 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 2021 except for the newly built and opened Ashford unit which has been physically inspected. The costs have been incorporated as part of the process for properties which have had major capital improvements since the previous valuation report. The effect of these valuations are recorded in note 15.1.

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 2021 applying indices for March 2021 which were available by the time the valuation was prepared. 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 not limited their opinion on the valuation report.

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.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements.

Note 2 Operating Segments

IFRS 8 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 2020/21 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 2020/21 accounts, Southern Health considers that it operates a single segment, 'healthcare', and segmental disclosures therefore do not need to be produced.

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)	2020/21	2019/20
	£000	£000
Mental health services		
Block contract / system envelope income*	175,290	157,673
Clinical income for the secondary commissioning of mandatory services	272	552
Other clinical income from mandatory services	1,822	1,985
Community services		
Block contract / system envelope income*	126,369	114,098
Income from other sources (e.g. local authorities)	25,868	27,126
All services		
Private patient income	5	3
Additional pension contribution central funding**	10,452	9,670
Other clinical income	-	937
Total income from activities	**340,078**	**312,044**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes.

The main increase in the year reflects income for Covid incurred expenditure and new investment in services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have 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.

Note 3.2 Income from patient care activities (by source)

	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	58,365	49,157
Clinical commissioning groups	255,902	229,102
Other NHS providers	3,481	7,137
Local authorities	19,325	20,300
Non-NHS: private patients	5	3
Injury cost recovery scheme	86	142
Non NHS: other	2,914	6,203
Total income from activities	**340,078**	**312,044**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

No income has been received in respect of overseas visitors (2019/20, nil).

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,217	-	**1,217**	1,530	-	**1,530**
Education and training *	8,347	500	**8,847**	8,080	407	**8,487**
Non-patient care services to other bodies	210	-	**210**	477	-	**477**
Provider sustainability fund (2019/20 only)	-	-	**-**	2,648	-	**2,648**
Financial recovery fund (2019/20 only)	-	-	**-**	1,539	-	**1,539**
Reimbursement and top up funding **	21,987	-	**21,987**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	2,373	-	**2,373**	2,208	-	**2,208**
Receipt of capital grants and donations	-	255	**255**	-	825	**825**
Charitable and other contributions to expenditure ***	-	3,313	**3,313**	-	17	**17**
Rental revenue from operating leases	-	2,770	**2,770**	-	3,058	**3,058**
Other income	2,208	-	**2,208**	4,515	-	**4,515**
Total other operating income	**36,342**	**6,838**	**43,180**	**20,997**	**4,307**	**25,304**

* Most of this income is received from Health Education England, £8,237k (2019/20 £8,077).

** This figure represents income required to support the service delivery in line with the financial regime for the whole of the NHS during pandemic response.

*** This figure represents the cost of centrally purchased PPE consumables provided to the Trust.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	2,514	2,267

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, (2019/20 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:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	339,427	308,462
Income from services not designated as commissioner requested services	651	3,582
Total	**340,078**	**312,044**

Note 5.4 Fees and charges

HM Treasury requires disclosure of fees and charges income to service users where income from that service exceeds £1 million. This Trust doesn't not have any schemes which exceed £1m in the current or prior year.

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,743	6,349
Purchase of healthcare from non-NHS and non-DHSC bodies	11,655	16,628
Staff and executive directors' costs	277,414	247,592
Remuneration of non-executive directors	183	169
Supplies and services - clinical (excluding drugs costs)	11,290	7,700
Supplies and services - general	9,384	7,217
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	4,066	4,348
Consultancy costs	3	59
Establishment	6,251	5,341
Premises	11,776	8,284
Transport (including patient travel)	2,807	4,183
Depreciation on property, plant and equipment	7,446	6,908
Amortisation on intangible assets	1,586	1,544
Net impairments	2,797	(1,655)
Movement in credit loss allowance: contract receivables / contract assets	(221)	253
Change in provisions discount rate(s)	59	-
Audit fees payable to the external auditors		
audit services- statutory audit	123	111
Internal audit costs	118	123
Clinical negligence	1,843	1,317
Legal fees	569	408
Insurance	344	282
Research and development	3	-
Education and training	1,639	1,155
Rentals under operating leases	16,725	12,796
Early retirements	2	4
Redundancy	-	35
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,331	1,271
Car parking & security	552	289
Hospitality	12	74
Losses, ex gratia & special payments	52	103
Other services, eg external payroll	3,579	3,102
Other	2,586	(932)
Total	**380,717**	**335,058**

Within other spend for 2019/20 there is the reversal of provisions for costs charged in the prior year which are no longer required, £1,362k.

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus resulting from:		
Abandonment of assets in course of construction	95	-
Unforeseen obsolescence	327	-
Changes in market price	2,375	161
Other	-	(1,816)
Total net impairments charged to operating surplus	**2,797**	**(1,655)**
Impairments charged to the revaluation reserve	2,233	6,613
Total net impairments	**5,030**	**4,958**

The Ashford unit opened in September 2020. It is a low secure residential accommodation facility for clients with learning disabilities. When a new property is brought into use, a revaluation takes place, this gave rise to a £705k impairment.

Included in the impairments for the year is the annual revaluation performed in January 2021 which resulted in a reduction in property value of £3.9m, £1.7m charged to expenditure and £2.2m charged to the revaluation reserve.

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	193,066	172,392
Social security costs	18,013	16,438
Apprenticeship levy	917	841
Employer's contributions to NHS pensions	34,408	31,799
Pension cost - other	62	62
Termination benefits	90	366
Temporary staff (including agency)	31,657	26,802
Total gross staff costs	**278,213**	**248,700**
Recoveries in respect of seconded staff	-	-
Total staff costs	**278,213**	**248,700**
Of which		
Costs capitalised as part of assets	799	1,073

Note 8.1 Retirements due to ill-health

During 2020/21 there were 2 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £57k (£175k in 2019/20).

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:

	2020/21 £000	2019/20 £000
Salary	1,200	1,132
Taxable benefits	4	8
Employer's pension contributions	53	77
Payment in Lieu of Notice	-	29
Total	**1,257**	**1,246**

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

National Employment Savings Trust (NEST)

In 2020/21 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 £147k (2019/20 £144k). 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% (2019/20 1.8%) charge on contributions plus an annual management charge of 0.3% (2019/20 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.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	2,770	3,058
Total	**2,770**	**3,058**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	2,814	3,039
- later than one year and not later than five years;	433	471
- later than five years.	227	256
Total	**3,474**	**3,766**

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.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	16,971	12,954
Less sublease payments received	(246)	(158)
Total	**16,725**	**12,796**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	12,448	12,961
- later than one year and not later than five years;	39,764	41,969
- later than five years.	43,958	7,556
Total	**96,170**	**62,486**
Future minimum sublease payments to be received	(508)	(517)

The NHS foundation Trust leases include:

24 properties from NHS Property Services Ltd with a total future commitment of £70,323k, (2019/20 £39,400k). There was an assumed occupancy of 5 years remaining in 2019/20, however this has been revised to 10 years in 2020/21 in the absence of formal leases.

Four properties leased from Community Health Partnerships Ltd have a future commitment of £9,948k, (2019/20 £6,700k).

Other significant operating lease commitments for properties with other landlords are: Avalon House £3,371k to December 2029, (2019/20 £2,994k), Black Horse House £2,299k to February 2024, (2019/20 £2,700k), Stoke Road Medical Centre £2,435k to April 2032, (2019/20 £2,653k), and the Parkway Centre £2,243k to February 2030, (2019/20 £1,910k).

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	£000
Interest on bank accounts	-	281
Total finance income	**-**	**281**

The national base interest rates for 2020/21 have reduced to minimal levels removing investment opportunities for the Trust.

Note 12 Finance expenses

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	-	3
Finance leases	4	4
Main finance costs on PFI and LIFT schemes obligations	825	846
Contingent finance costs on PFI and LIFT scheme obligations	402	359
Total finance costs	**1,231**	**1,212**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21	2019/20
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	42	32

Note 12.3 PDC Dividend Cash Movements

	2020/21	2019/20
	£000	£000
PDC dividends payable / (receivable) at April	88	(316)
Charge for the year	4,491	4,733
PDC dividends receivable / (payable) at March	114	(88)
PDC dividends paid in year	**4,693**	**4,329**

Note 13 Other gains / (Losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	609	24
Losses on disposal of assets	-	(3)
Total other gains	**609**	**21**

Three adjoining properties that have been classified as held for sale since 2016/17 were sold in April 2020 giving rise to a gain of £609k.

Note 14.1 Intangible assets - 2020/21

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
Gross cost at 1 April 2020	**2,635**	**6,075**	**22**	**8,732**
Additions	151	180	514	**845**
Impairments	(94)	(66)	(22)	**(182)**
Reclassifications	2	189	(191)	**-**
Disposals / derecognition	(1,113)	(3,777)	-	**(4,890)**
Gross cost at 31 March 2021	**1,581**	**2,601**	**323**	**4,505**
Amortisation at 1 April 2020	**1,391**	**4,027**	**-**	**5,418**
Provided during the year	553	1,033	-	**1,586**
Disposals / derecognition	(1,113)	(3,777)	-	**(4,890)**
Amortisation at 31 March 2021	**831**	**1,283**	**-**	**2,114**
Net book value at 31 March 2021	**750**	**1,318**	**323**	**2,391**
Net book value at 31 March 2020	**1,244**	**2,048**	**22**	**3,314**

Note 14.2 Intangible assets - 2019/20

	Software licences	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000
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)**
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 / derecognition	(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 15.1 Property, plant and equipment - 2020/21

	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 2020	**41,643**	**145,475**	**455**	**8,897**	**7,811**	**84**	**6,973**	**725**	**212,063**
Additions	-	1,550	-	8,571	718	-	2,855	41	**13,735**
Impairments	-	-	-	(73)	(18)	-	(149)	-	**(240)**
Revaluations	455	(9,486)	1	-	-	-	-	-	**(9,030)**
Reclassifications	-	11,345	-	(11,491)	51	-	12	83	**-**
Disposals / derecognition	-	(327)	-	-	(2,450)	(60)	(2,280)	(17)	**(5,134)**
Valuation/gross cost at 31 March 2021	**42,098**	**148,557**	**456**	**5,904**	**6,112**	**24**	**7,411**	**832**	**211,394**
Accumulated depreciation at 1 April 2020	**-**	**1,548**	**2**	**-**	**4,531**	**66**	**3,350**	**290**	**9,787**
Provided during the year	-	4,830	19	-	1,085	12	1,417	83	**7,446**
Impairments	-	4,713	-	-	-	-	-	-	**4,713**
Reversals of impairments	-	(105)	-	-	-	-	-	-	**(105)**
Revaluations	-	(9,871)	(18)	-	-	-	-	-	**(9,889)**
Disposals / derecognition	-	(327)	-	-	(2,450)	(60)	(2,280)	(17)	**(5,134)**
Accumulated depreciation at 31 March 2021	**-**	**788**	**3**	**-**	**3,166**	**18**	**2,487**	**356**	**6,818**
Net book value at 31 March 2021	**42,098**	**147,769**	**453**	**5,904**	**2,946**	**6**	**4,924**	**476**	**204,576**
Net book value at 31 March 2020	**41,643**	**143,927**	**453**	**8,897**	**3,280**	**18**	**3,623**	**435**	**202,276**

Note 15.2 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 / derecognition	-	(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 15.3 Property, plant and equipment financing - 2020/21

	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 2021									
Owned - purchased	42,098	129,550	453	5,904	2,041	6	4,878	476	**185,406**
Finance leased	-	328	-	-	-	-	-	-	**328**
On-SoFP PFI contracts and other service concession arrangements	-	17,081	-	-	-	-	-	-	**17,081**
Owned - donated/granted	-	810	-	-	905	-	46	-	**1,761**
NBV total at 31 March 2021	**42,098**	**147,769**	**453**	**5,904**	**2,946**	**6**	**4,924**	**476**	**204,576**

Note 15.4 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/granted	-	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 16 Donations of property, plant and equipment

The Friends of Lymington New Forest Hospital have donated an Ultrasound machine, £61k and the Romsey Hospital League of Friends have donated a bladder scanner, £6k.

Grants have been received of £188k from the Low Carbon Scheme which is supporting the LED lighting initiative across several sites.

Note 17 Revaluations of property, plant and equipment

	2020/21	2019/20
	£000	£000
Revaluation at 1 April	55,551	55,523
Impairments	(2,233)	(6,613)
Revaluations	859	6,641
Revaluation at 31 March	**54,177**	**55,551**

The valuation this year was a desktop and good housekeeping review with the exception of a physical inspection which took place when the new Ashford unit which opened to residents in September 2020. A physical inspection of other properties was not deemed to be appropriate given access restrictions in place due to Covid-19 at the time they would have been needed. The valuation has included an assessment of major capital expenditure in units since last year's valuation report.

- the effective date of the most recent valuation is 31 January 2021 using the March 2021 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; and
- the estimated remaining lives are assessed as part of the valuation.

Much of the change has arisen following changes in the optimisation and utilisation of the estate and downward movement in indices published by RICS.

Note 18 Disclosure of interests in other entities

Note 18.1 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 2021 are summarised below.

Charity's Statement of Financial Activities	Unaudited 2020/21 £000	Audited 2019/20 £000
Total incoming resources	352	738
Cash resources expended	(270)	(1,057)
Net outgoing resources	**82**	**(319)**
Gain/(Loss) on revaluation and disposal plus other fund movements	102	(12)
Net movement in funds	**184**	**(331)**

Charity's Balance Sheet (Statement of Financial Position)	Unaudited 31 March 2021 £000	Audited 31 March 2020 £000
Investments	658	556
Total fixed assets	**658**	**556**
Cash	67	11
Current liabilities	(16)	(42)
Net assets	**709**	**525**
Restricted / endowment funds	418	292
Unrestricted funds	291	233
Total charitable funds	**709**	**525**

Note 18.2 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

	2020/21 £000	2019/20 £000
Clinical Income	6,462	5,727
Non Clinical Income	58	141
Non Pay Costs	(1,500)	(1,407)
Pay Costs	(5,271)	(4,971)
Net Primary Care Expenditure	**(251)**	**(510)**

Note 19 Inventories

	31 March 2021 £000	31 March 2020 £000
Consumables	57	85
Total inventories	**57**	**85**

Inventories recognised in expenses for the year were £3,313k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £3,313k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 20.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	4,561	14,282
Allowance for impaired contract receivables / assets	(239)	(492)
Prepayments (non-PFI)	2,287	1,629
PDC dividend receivable	114	-
VAT receivable	1,969	3,943
Other receivables	9	61
Total current receivables	**8,701**	**19,423**
Non-current		
Other receivables	397	338
Total non-current receivables	**397**	**338**
Of which receivable from NHS and DHSC group bodies:		
Current	5,413	13,468
Non-current	397	338

To ease the administrative burden during 2020/21 the financial regime required the number of invoices raised within the NHS to be reduced significantly impacting the balance of unpaid receivables at the end of March 2021.

Note 20.2 Allowances for credit losses

	2020/21 Contract receivables and contract assets	2019/20 Contract receivables and contract assets
	£000	£000
Allowances as at 1 April	**492**	**246**
New allowances arising	114	362
Changes in existing allowances	(48)	(55)
Reversals of allowances	(287)	(54)
Utilisation of allowances (write offs)	(32)	(7)
Allowances as at 31 March 2021	**239**	**492**

Note 21 Non-current assets held for sale

	2020/21	2019/20
	£000	£000
NBV of non-current assets for sale at 1 April	**1,818**	**1,818**
Assets sold in year	(1,818)	-
NBV of non-current assets for sale at 31 March	**-**	**1,818**

Note 22.1 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.

	2020/21	2019/20
	£000	£000
At 1 April	**13,281**	**20,405**
Net change in year	33,471	(7,124)
At 31 March	**46,752**	**13,281**
Broken down into:		
Cash at commercial banks and in hand	88	81
Cash with the Government Banking Service	46,664	13,200
Total cash and cash equivalents as in SoFP	**46,752**	**13,281**
Total cash and cash equivalents as in SoCF	**46,752**	**13,281**

Note 22.2 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 2021	31 March 2020
	£000	£000
Bank balances	139	145
Total third party assets	**139**	**145**

Note 23.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	14,299	12,657
Capital payables	4,813	1,784
Accruals	17,089	6,547
Receipts in advance and payments on account	947	3,890
Social security costs	2,647	2,460
Other taxes payable	1,355	1,120
PDC dividend payable	-	88
Other payables	6,235	4,820
Total current trade and other payables	**47,385**	**33,366**
There are no non-current payables, (2019/20, nil).		
Of which payables from NHS and DHSC group bodies:	7,512	7,978

Note 24 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	10,787	5,654
Total other current liabilities	**10,787**	**5,654**

Note 25.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	-	5,003
Obligations under finance leases	1	1
Obligations under PFI, LIFT or other service concession contracts	361	417
Total current borrowings	**362**	**5,421**
Non-current		
Obligations under finance leases	83	83
Obligations under PFI, LIFT or other service concession contracts	14,845	15,207
Total non-current borrowings	**14,928**	**15,290**

Following a decision on 2 April 2020 by the Department of Health and Social Care, the Trust received Public Dividend Capital to allow repayment of the DHSC Loan in September 2020.

Note 25.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**5,003**	**84**	**15,624**	**20,711**
Cash movements:				
Financing cash flows - payments and receipts of principal	(5,000)	-	(418)	**(5,418)**
Financing cash flows - payments of interest	(3)	(4)	(825)	**(832)**
Non-cash movements:				
Application of effective interest rate	-	4	825	**829**
Carrying value at 31 March 2021	**-**	**84**	**15,206**	**15,290**

Note 25.3 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 26 Finance Leases as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2021	31 March 2020
	£000	£000
Gross lease liabilities	**195**	**200**
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.	172	177
Finance charges allocated to future periods	(111)	(116)
Net lease liabilities	**84**	**84**
of which payable:		
- not later than one year;	1	1
- later than one year and not later than five years;	2	2
- later than five years.	81	81

Note 27.1 Provisions for liabilities and charges analysis

	Pensions injury benefits	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**36**	**253**	**296**	**425**	**1,010**
Change in the discount rate	-	-	-	59	**59**
Arising during the year	-	83	1,920	219	**2,222**
Utilised during the year	(6)	(77)	(67)	-	**(150)**
Reversed unused	-	(89)	(200)	-	**(289)**
At 31 March 2021	**30**	**170**	**1,949**	**703**	**2,852**
Expected timing of cash flows:					
- not later than one year;	5	85	1,462	**25**	**1,577**
- later than one year and not later than five years;	20	85	487	**35**	**627**
- later than five years.	5	-	-	**643**	**648**
Total	**30**	**170**	**1,949**	**703**	**2,852**

The new restructuring provision has arisen due to a number of internal re-organisations.

Included in the other provisions balance are dilapidation costs and a commitment to fund clinicians' 2019/20 tax cost under the Scheme Pays Initiative.

Note 27.2 Clinical negligence liabilities

At 31 March 2021, £12,412k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Southern Health NHS Foundation Trust (31 March 2020: £8,382k).

Note 28 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(154)	(221)
Gross value of contingent liabilities	**(154)**	**(221)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(154)**	**(221)**
Net value of contingent assets	**-**	**-**

Note 29 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	2,134	1,694
Total	**2,134**	**1,694**

Note 30 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 31 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 31.1 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 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**41,518**	**43,078**
Of which liabilities are due		
- not later than one year;	1,579	1,641
- later than one year and not later than five years;	7,990	7,486
- later than five years.	31,949	33,951
Finance charges allocated to future periods	(26,312)	(27,454)
Net PFI, LIFT or other service concession arrangement obligation	**15,206**	**15,624**
- not later than one year;	361	417
- later than one year and not later than five years;	2,612	2,269
- later than five years.	12,233	12,938

Note 31.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**64,925**	**67,428**
Of which payments are due:		
- not later than one year;	2,702	2,631
- later than one year and not later than five years;	11,500	11,197
- later than five years.	50,723	53,600

Note 31.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21 £000	2019/20 £000
Unitary payment payable to service concession operator	**2,636**	**2,567**
Consisting of:		
- Interest charge	825	846
- Repayment of balance sheet obligation	418	400
- Service element and other charges to operating expenditure	794	772
- Revenue lifecycle maintenance	197	190
- Contingent rent	402	359
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	415	312
Total amount paid to service concession operator	**3,051**	**2,879**

Note 32 Financial instruments

Note 32.1 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 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 20.2 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 22.1, all material balances of the NHS Foundation Trust's £46.8 million (2019/20 £13.3 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.

The NHS Foundation Trust has sufficient cash to meet its day to day operations throughout 2021/22. If in unusual circumstances there is a risk of insufficient operating cash, then a business case would be put to NHS England and NHS Improvement to apply for cash support.

Note 32.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	4,728	**4,728**
Cash and cash equivalents	46,752	**46,752**
Total at 31 March 2021	**51,480**	**51,480**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	14,189	**14,189**
Cash and cash equivalents	13,281	**13,281**
Total at 31 March 2020	**27,470**	**27,470**

Note 32.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	84	**84**
Obligations under PFI, LIFT and other service concession contracts	15,206	**15,206**
Trade and other payables excluding non financial liabilities	42,436	**42,436**
Provisions under contract	2,652	**2,652**
Total at 31 March 2021	**60,378**	**60,378**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	5,003	**5,003**
Obligations under finance leases	84	**84**
Obligations under PFI, LIFT and other service concession contracts	15,624	**15,624**
Trade and other payables excluding non financial liabilities	25,720	**25,720**
Provisions under contract	721	**721**
Total at 31 March 2020	**47,152**	**47,152**

Note 32.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	45,508	33,552
In more than one year but not more than five years	8,530	7,539
In more than five years	32,764	34,493
Total	**86,802**	**75,584**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

The main elements affected are the long term liabilities for the two finance leases in operation, the total previously published for 2019/20 was £47,152k which is now restated to £75,584k.

Note 33 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	27	5	1	-
Bad debts and claims abandoned	28	36	42	12
Total losses	**55**	**41**	**43**	**12**
Special payments				
Compensation under court order or legally binding arbitration award	23	83	6	12
Ex-gratia payments	29	35	23	32
Total special payments	**52**	**118**	**29**	**44**
Total losses and special payments	**107**	**159**	**72**	**56**

Note 34 Related parties

The NHS Foundation Trust is an independent public benefit corporation as authorised by Monitor working with NHS Improvement in its NHS Provider Licence.

The transactions during 2020/21 and 2019/20 detailed below were related by virtue of the Board member listed along with their role in the third party.

		Receivables		Payables	
		31-Mar-21	31-Mar-20	31-Mar-21	31-Mar-20
		£000	£000	£000	£000
(i)	The Willow Group (Paula Hull, General Partner)	0	284	0	1
(ii)	Southern Health NHS Foundation Trust General Fund Charity Reg No: 1089307 (All directors Trustees of the charity)	0	37	0	0
(iii)	Wessex Academic Health Science Network Ltd (Dr Nick Broughton)	0	0	0	0
	Total	-	321	-	1

		Income		Expenditure	
		2020/21	2019/20	2020/21	2019/20
		£000	£000	£000	£000
(i)	The Willow Group (Paula Hull, General Partner)	0	6,088	2	43
(ii)	Southern Health NHS Foundation Trust General Fund Charity Reg No: 1089307 (All directors Trustees of the charity)	0	901	0	0
(iii)	Wessex Academic Health Science Network Ltd (Dr Nick Broughton)	0	15	0	0
	Total	-	7,004	2	43

(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) Dr Nick Broughton is a board member of the Wessex Academic Health Service Network.

All of the transactions listed above and below are unsecured and under no guarantees.

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.

	2020/21		2019/20		2020/21		2019/20	
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	-	1,870	-	1,410	-	-	-	62
NHS Fareham And Gosport CCG	-	32,865	50	30,696	-	578	-	110
NHS North East Hampshire and Farnham CCG	-	188	25	473	-	-	-	16
NHS North Hampshire CCG	-	31,300	-	29,797	-	16	-	80
NHS Portsmouth CCG	-	1,868	-	4,384	-	-	-	60
NHS South Eastern Hampshire CCG	40	59,711	36	38,211	53	652	12	155
NHS Southampton CCG	-	30,800	-	30,093	105	-	2,542	5
NHS West Hampshire CCG	-	98,727	43	94,595	-	164	2	1,747
Isle of Wight NHS Trust	337	62	102	427	262	-	9	51
Portsmouth Hospitals NHS Trust	2,433	1,070	2,148	1,083	587	196	388	98
Solent NHS Trust	1,843	1,053	3,053	942	780	289	484	218
NHS England	11	68,772	19	43,543	299	1,339	1,080	3,682
Health Education England	-	8,997	12	8,077	470	295	134	265
NHS Resolution (formerly NHS Litigation Authority)	2,104	-	1,530	-	-	-	-	-
NHS Property Services Ltd	11,405	9	7,637	8	3,557	25	1,893	38
Community Health Partnerships	893	(5)	751	2	46	-	159	5
Department of Health	-	548	-	473	18	-	-	-
Frimley Health NHS Foundation Trust	21	807	21	1,077	3	401	12	802
University Hospital Southampton NHS Foundation Trust	4,108	3,931	3,827	4,346	1,812	716	1,786	1,979
Hampshire Hospitals NHS Foundation Trust	2,287	747	2,241	716	516	91	431	158
Oxford Health NHS Foundation Trust	2	129	2	3,398	1	259	-	3,295
Salisbury NHS Foundation Trust	358	-	231	9	3	-	35	3
Midlands Partnership NHS Foundation Trust	-	436	17	576	106	60	107	235
South Central Ambulance Service NHS Foundation Trust	302	-	262	-	65	-	22	-
Hampshire County Council	825	19,448	492	20,438	5,547	93	1,696	119
Southampton City Council	12	268	69	253	12	48	53	45
Winchester City Council	547	-	479	-	132	-	179	-
NHS Shared Business Services	270	-	413	-	-	-	-	-
NHS Professionals	28,539	-	-	-	2,479	-	-	-
HM Revenue & Customs Other taxes	18,930	-	17,279	-	4,002	-	3,580	-
NHS Pension Scheme	34,408	-	31,799	-	3,317	-	3,045	-
HM Revenue & Customs - VAT	-	-	-	-	-	1,969	-	3,943

Note 35 Events after the reporting date

No events have taken place which need to be declared.

Note 36 Contact Details

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